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The Effects Of Social Status On The Quality And Affordability Of Healthcare

Robert Burns

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The most basic human right is the right to life, and in the modern era this is provided through the ability of an individual to have access to proper healthcare. However, not everyone has the same access to the care they need. Countries have differing systems of health insurance and medical coverage and each system possesses traits that affect how people receive healthcare based off of their socioeconomic status. For example, in the American healthcare system, if an individual is unable to purchase health insurance then they are charged extravagant fees for hospital visits, and this plunges them further into debt. In contrast, Canada, a very similar country culturally, has a publicly funded healthcare system, so even those who cannot afford medical care can still receive treatment, with much of the cost being distributed through public taxes. In fact, in 2012, the average out of pocket cost for Canadian citizens to receive healthcare was $3,380 USD, while United States citizens paid $8,388 (OECD 2014). In some studies, as discussed later, researchers have discovered that those of a lower socioeconomic status (SES) have higher mortality rates to a variety of diseases and conditions for which plenty of treatment is feasible (Niu, Zhao, Zhu, Liu, Liu, Liu, Wang, and Smith 2009). In all cases, SES was determined based off of an individual's level of education attainment and their occupation with associated income. It can thus be assumed that the increased mortality in lower SES brackets is due, in part, to a decreased capacity to afford proper treatment, which is influenced negatively by having less education and thus fewer employment opportunities. Additionally, lower SES individuals have been shown to have increased risk of health issues due to a higher likelihood of partaking in unhealthy lifestyles, including smoking and obesity (Mackenbach, Stirbu, Roskam, Schaap, Menvielle, Leinsalu, and Kunst 2008), which only serves to increase the costs of medical care for these individuals.
An individual’s status does more than just affect their access to healthcare, it also alters the way they interact with physicians. Many studies have been performed since the mid-1900s in an attempt to understand the factors behind how patient-doctor interactions play out, and most of these studies have demonstrated a link between patients' SES and their interactions with physicians. Types of patient/physician interactions include those that are physician-dominated, in which the patient plays a very passive role in their own treatment, and mutualistic, where the physician and patient work together to achieve success. Increasingly mutualistic interactions between the doctor and his or her patient have been shown to lead to better medical outcomes. However, a significant difference in the SES of the patient and the SES of the physician can act as a barrier towards cooperation (Peck and Conner 2011).

In this paper, I will first review previous studies done that link socioeconomic status to the quality of medical care. These will give a basic understanding of the economic inequality present in healthcare access as well demonstrate how this is a universal issue rather than solely an American one. Next, I will present studies that have further linked socioeconomic status to the quality of interactions between healthcare professionals and their patients. Such studies have defined how social status affects the sociology and psychology behind what occurs in the doctor's office. Ultimately, we will relate the social inequalities of accessibility to healthcare to the unequal treatment that social class facilitates. This relationship can then be utilized as a framework from which new ideas can be proposed in order to improve medical treatment of those less fortunate.
**SES and Healthcare**

The socioeconomic status of populations can vary greatly between countries, even those located close together, such as in Europe. A recent study by the European Union Working Group on Socioeconomic Inequalities in Health examined how education, occupation, and income affected the need for various medical treatments in 22 European countries. The study found that the southern and eastern countries tended to have lower education and wealth, while northern and western countries had larger gaps between the highest and lowest classes. With regards to health, the less wealthy countries had higher rates of death across a variety of causes, particularly in treatable illnesses such as tuberculosis and hypertension. For example, Lithuania, one of the southeastern countries, experienced over three times as many deaths per person-years due to amenable causes than Spain, a western country, at 7.7% and 2.5% of all deaths respectively. In addition, in the countries with the most pronounced stratification of lowest to highest social class, rates of smoking and obesity increase significantly in the lowest classes, even by a factor of four in the case of obesity, compared to the highest. (Mackenbach, et al. 2008). The data shown here gives credence to two major issues: 1.) poorer social classes do not have proper access to affordable healthcare, evident by high rates of mortality from amenable causes, and 2.) a lower social class increases the necessity of having affordable healthcare due to increased prevalence of health risk behaviors such as smoking and obesity.
In another study, this time performed in China, researchers examined the treatment rates of preventative medication for coronary heart disease and its association with socioeconomic status. As shown in figure 1, those in the lowest SES bracket possessed only 6.7% and 34.2% treatment rates of clopidogrel and statins, drugs used to prevent blood clotting and lower cholesterol, respectively. Meanwhile in the same study group, those in the highest SES bracket showed 41.7% and 75% treatment rates for the same drugs. Additionally, aspirin and β-blocker treatment showed a 43.4% and 70.2% reduction in treatment in the lowest bracket than the highest after adjusting for various cofactors (Niu, Zhao, Zhu, Liu, Liu, Liu, Wang, and Smith 2009). One of the major reasons for these inequalities in healthcare is that the government expenditure on actual medical costs through insurance and similar programs only amounts to 36% of the health budget in China, which leaves the population as a whole paying approximately 60% of their medical payments out-of-pocket, leading to a decrease in the amount of patients who can afford to pay for their medications. Furthermore, when the
population is examined as smaller subsections, 76% and 79.9% of those in the lowest income bracket in rural and urban areas, respectively, do not own medical insurance, even further increasing the likelihood of avoiding paying for such expenses (Niu et al. 2009).

Being forced to avoid medication due to cost is not solely an issue in China, of course. Poverty is a universal issue and so are the decisions that a family must make in order to keep themselves from falling even further into it. One last study that we will look at on the economical side of healthcare is that of Robin Weinick, Sepheen Byron, and Arlene Bierman, (2005) who examined the proportion of Americans who feel that they face at least one significant barrier to affording healthcare, as well as how they went about avoiding such costs (Weinick, Byron, Bierman 2005).

First, costs of medical insurance were compared between the years of 2001, 2002, and 2003, for which data was available. Between 2001 and 2003, the average percentage of Americans covered by private insurance plans dropped from 70.9% to 68.6% (DeNavas-Walt, Proctor, Mills 2004). While this is only a 2.3% drop, it represents the results of a significant increase in the price of premiums, copayments, and out-of-pocket maximums that occurred during the same time-span for many insurance programs (The Mercer Report 2004). Additionally, in 2001 there were 41.2 completely uninsured American citizens, compared to 43.6 in 2002 and 45.0 in 2003, further lending evidence that increased insurance costs are increasing the likelihood of families to forgo such programs (DeNavas et al. 2004; Mills and Bhandar 2002).
Using the Commonwealth Fund 2001 Healthcare Quality Survey, Weinick, Byron, and Bierman examined information about experiences with affording healthcare. The measures of having difficulty paying for healthcare included situations such as postponing healthcare due to costs, avoiding filling prescriptions due to cost, difficulty seeing a needed specialist, avoided following a physician’s orders due to cost, and the use of cheaper alternative medicines. Results showed that 16.9% of Americans experienced at least one of these problems, which rose to 40% among those that were uninsured. Furthermore, of those 40%, one in four reported their barrier as being the first measure, that of putting off treatment due to cost. Additionally, 20% and 13.6% of Medicaid-covered and privately insured adults, respectively, reported facing barriers at least one of these barriers to receiving healthcare despite insurance being able to cover the brunt of the cost (Weinick et al. 2005).

**SES and Patient-Physician Interaction**

A low socioeconomic status has quite the detrimental effect on one’s access to healthcare, as demonstrated in the above studies. However, less apparent is the impact it has on the social interaction between a patient and their physician, which we will look at next. Before this could be studied, however, researchers first had to uncover the basic principles behind the patient-doctor interaction.

Defining the nature of patient-doctor interactions began in the mid-twentieth century. One of the most cited early pieces was written in 1951, where researcher Talcott Parsons described an early model of this interaction, which he called the paternal model. He described the doctor as being paternalistic, or the one with the most control and power over the situation.
(Parsons 1951). This represented a very unequal balance of power in these interactions, which left the patient with little say in their own medical care. Many years later, in 2006, John Heritage and Douglas Maynard further characterized the patient-doctor interaction by adding to Parsons’ model. In their paper, they described the typical physician of the time to be using generalized standards of treatment, dubbed universalism, as opposed to adjusting their treatment based on the social characteristics of who they were treating, which would be entitled particularism. Additionally, the physician took on a very specific and technical role as opposed to acting as a counselor for the patient, which would help enforce a two-way interaction. To complement the technical role of the physician, patients adopt the sick role, wherein they would be considered exempt from most duties and responsibility, but are required to maintain motivation to get well (Heritage and Maynard 2006).

Like all theories, the Parsons model is not without its faults. One of these was described by Parson himself. Parson mentions that his model is quite abstract, as it was only designed to handle a very general overview of the patient-doctor interaction, and thus wasn't readily adaptable to a variety of illnesses (Parsons 1951, p. 440). This topic was quickly addressed by Szasz and Hollender only five years after Parsons, in which they observed that patients who suffer from chronic diseases that can be treated by self-administered medication exhibit more mutualistic relationships with their physicians than patients who must undergo surgery or other physician-intensive treatments (Szasz and Hollender 1956).

Another issue that modern researchers have with accepting the Parsons model is that the time period of when he wrote his article was much more heavily skewed in the physicians favor that modern day. During the 1945 to 1965 era, the medical profession was at an all time
high in terms of "prestige, prosperity, and political and cultural influence - perhaps as autonomous as it is possible for a profession to be" (Freidson 1988; Heritage and Maynard 2006). Furthermore, the profession was deemed by others to have possessed a binary role in administering medication as well as performing a judgmental role in seeing to the patient (Starr 1982, Heritage and Maynard 2006).

Parsons was not alone in writing on the dominant-subordinate dichotomy of the patient-doctor interaction. One year earlier, sociology professor Dorothy Bourne discussed the situation in her article entitled “Doctor-Patient Relationship.” A critical factor in this era was the rise of popular magazines, many of which discussed ever dangerous diseases, psychosocial disorders, and incredible new drugs for which to treat these. At this point, a new pressure was placed on physicians as they had more patients claiming to have a variety of diseases and mental illnesses, not unlike modern day issues with self-diagnoses and the internet. Thus, many patients came to their doctors out of fear, but not without some semblance of knowledge with which they can attempt to have an equal discussion with their doctor. The doctor is now faced with a dilemma on whether they should attempt to work with the patient so as to facilitate a better understanding of medicine, or if they should assume the traditional authoritarian role (Bourne 1950). While the authoritarian role may provide a quicker visit to the doctor, the patient lacks the understanding of their treatment that is key to keeping them motivated to see their regimen of drugs, exercise, or habits through. Bourne describes two types of patients: The “good” patient, who allows the doctor absolute authority, and the “bad” patient, who, in a sense, rebels against the doctor and aims to have agency in their own treatment. An excellent analogy given for this situation was that the “bad” patient is like that of a child who wishes to
tie their own shoes. A parent could tie the shoes for their child every day and get it done quicker, but the child will never actually learn to do it for themselves. However, if the child always wishes to tie their shoes themselves without any help, they may eventually succeed but only after much trial and error, which is obviously not acceptable in the case of a sick patient. The most ideal way of addressing these two roles then is to mix them to form a mutual interaction based off of cooperation. In this scenario, a patient assumes the “bad” patient role by not giving over full control of the situation, but also incorporate the “good” patient by understanding that they possess limited knowledge and accordingly integrate what they know and what they are told by those who do have such knowledge, in this case the physician (Bourne 1950).

Researchers Debra Roter and Judith Hall put forth an updated model of defining patient-doctor interactions in 1992, which expanded upon the paternal and mutualistic models by combining them among a series of possible interaction types (Roter and Hall 1992). Physicians and patients are rated in each situation to be either in high or low control, and then the situations are split into four categories, as seen in figure 2. The paternalistic model set forth by Parsons would fall under a physician with high control and patient with low control, as the physician dominates the interaction and receives little input from the patient. Should the tables turn and the patient be the only one with high control, thus a doctor with low control, then the situation would fall under the consumerist model. In the consumerist model, the physician is very passive and fulfills the desires of the patient without much hesitation. Roter and Hall dubbed the case in which neither the physician or the patient exhibit high control over the situation as the default model, or one in which neither party fully commits to the problem.
solving process that is medicine. Finally, should both the patient and doctor maintain high control, then they are working under the mutuality model. This model would likely be what is most beneficial for the patient, as, like the Bourne model, decision making and critical thinking is shared amongst both parties in order to work together to better the patient's well-being (Roter and Hall 1992).

Within recent decades, the medical field has seen a stronger push towards becoming closer to the mutualistic model that Bourne laid out in place of the Parsons model (Brody, Miller, Lerman, Smith, and Caputo 1989; Falkum and Førde 2001). By increasing the autonomy of the patient, many issues regarding patient’s needs can be better addressed, such as the elimination of inaccurate diagnoses by helping doctors to better understand their patient’s medical history through true conversation rather than something akin to a rough questioning. Additionally, increasingly mutualistic interactions have been linked to increased program attendance, decreased smoking, better self-monitoring of glucose, committal to exercise and weight loss, and increased adherence to treatment regimens (Frankel, Quill, and McDaniel 2003). Despite the benefits of the mutualistic model, modern research shows that interactions between physicians and patients more often than not resembles the paternal model of Parsons...
instead (Fiscella, Meldrum, Franks, Shields, Duberstein, McDaniel, and Epstein 2004; Levinson, Roter, Mullooly, Dull, and Frankel 1997; Stewart, Brown, Donner, McWhinney, Oates, Weston, and Jordan 2000).

With this better understanding of the patient-doctor interaction, research has changed direction in recent years towards more specific inquiries on the topic. Primarily, social status has been discovered to be a predominant factor in what determines the nature of the interaction. In a 2011 study done by B. Mitchell Peck of the University of Oklahoma and Sonya Conner of Worcester State University, patient-doctor interactions were studied with a focus on the social standing of the patients in regards to the doctors in order to see what effect this had on their treatment. Using a theory known as the Status Characteristics Theory (SCT), the researchers attempted to analyze patient-doctor relationships based off of the patient’s social status (Peck and Conner 2011). This theory is based in the expectation-states theory, which states that expectations of one individual from another are highly important to the interactions between these individuals (Berger 1958). With regards to SCT and the expectation-states theory, interactions will be affected by expectations based predominantly on socioeconomic status, including wealth and prestige, ethnicity, and gender (Peck and Conner 2011).

Generally, when an individual is interacting with someone who has higher prestige than themselves, that individual will place higher expectations on their partner (Peck and Conner 2011). In the case of the doctor and patient, a patient who holds a more renowned position or possesses high socioeconomic status might be given more leeway to express their own thoughts and concerns over their treatment as well as higher credence given to their self-
diagnosis. Other highly important attributes tested in the Peck and Connor study were the race and gender of patients in relation to their physician interaction. In this study, they found that race resulted in a ratio of physician dominated to patient dominated interactions between 1.70 and 1.77, and a gender based ratio of 1.44 to 1.71. These were under conditions where the physicians, who were 82.4% white and 58.8% male, were interacting with patients of different racial backgrounds and gender, which led to an increase in physician dominated encounters. This shows that expectations are set not only on prestigious titles and income, but also on more basic characteristics of an individual.

Patients are not the only members of a medical interaction that can be placed under increased pressure based on their social status. In a 1964 study, it was observed that psychiatric nurses who perceived themselves as of a lower class than their patients felt a sense of intimidation and felt out of place when providing care (Segal, 1964). In this study, the nurses’ status was quantified using three variables: their spouse’s occupations, their sex, and the amount of formal education the nurse attained. The Index of Relative Status (IRS) averaged out to 9 among the nurses, while a similarly obtained IRS for the psychiatric patients had an average of 10.6, significantly different from the nurses. In addition, over 80% of the nurses classified their patients in the upper class, while not a single nurse reported themselves to be above the middle class. When asked for these classifications, the nurses generally agreed that they felt out of place amongst the patients as they do not share similar lifestyles and that interpersonal communication was difficult. Lastly, a scale known as the Status Disaffection Scale was used to further assess the nurse-patient social stratification, which is shown in figure 3. A higher value on this scale represents a higher perceived social distance between the nurse and
the patient, thus the nurse is thought to be more upset by the social status of the patient. Furthermore, the higher score is an indication that the nurse believes she is limited in her ability to perform her duties in a satisfactory manner due to the gap in the two social statuses. These limitations may be placed on her work through a multitude of reasons, including unreasonable requests that feel difficult to ignore due to the patients social status or a lack of respect from the patients that then leads to aggravation in the nurse. In order to regain confidence in their profession, which many nurses felt was only prestigious in the eyes of other nurses rather than their patients, the nurses followed similar roles to the ones defined by Parsons, where “the sick” possessed different expectations from normal that, in a sense, lowered their standing in the social hierarchy for the time that the nurses care for them. This legitimation of their social status allowed the nurses to attain a higher sense of authority in their work and increase their own levels of self-respect (Segal 1964).

We have seen that with a lower socioeconomic status comes the inability to properly afford important medical care, in some cases with chronic, life-threatening illnesses. The BRIG
study (2009) showed us that treatment rates dropped drastically among those of the lower classes, while the Weinick (2005) article discussed how families will purposely avoid seeking treatment in cases where they feel afraid of having to pay exorbitant fees. Having to not worry about one’s personal health is one of the most important facets of life, but in many cases this is simply not possible due to a lack of funds. Additionally, should you seek medical attention while in these circumstances, chances are that your interaction with your physician may not be optimal. Expectations of the patient are lower when coming from a lower social class, and as such the physician will be less willing to accept their input. In the case of a medical history, it is critical that the patient-doctor relationship is as open as possible, but when the patient feels less in control due to an authoritative interaction, important details can be left out in an attempt to avoid further cooperation, or in some cases patients may not feel ready to reveal parts of their medical history that they may deem sensitive, such as drug use or sexually-transmitted diseases. This can have devastating effects on the type of treatment a doctor prescribes, as well as on the manner in which the patient follows such treatment.

What, then, are possible solutions to these issues? Seeing as both arise from socioeconomic status, this would be the ideal target for reform. To begin, let us look at simply affording healthcare. In most countries, insurance is the most convenient way of paying for medical expenses, but is not always an option for poorer families. One very famous solution for this issue was the Affordable Care Act passed recently in the United States. Of the many provisions this act provides, many are focused at increasing the range of health insurance coverage to include more of the lower class. Examples of this include an increase in the cut off point for eligibility towards Medicaid coverage to 138% of the national poverty line, providing
an affordable Basic Health Program to those between 138% and 200% of the national poverty line, and increasing subsidies on health insurance for those of the lower class while raising taxes for the opposite end of the social spectrum (Blumberg 2012). However, states are allowed to opt out of expanding their Medicaid coverage, meaning that some states will still see a gap between those who are eligible for Medicaid and those who can comfortably afford insurance using marketplace subsidies. As of now, 16 states have still not expanded their coverage, leaving a significant number of citizens stuck in this gap (Status of State Action on the Medicaid Expansion Decision 2015). Additionally, families who can afford health insurance but choose not to face a penalty fee, which can be as high as 2% of your yearly income or $325 per person, whichever is higher (Individual Mandate Penalty You Pay If You Don’t Have Health Insurance Coverage 2015). This does not pose much of a threat to those who are living at a modest income without debt, but those who do have debt or are just barely making enough money to pass the threshold for this penalty will be hit harder by having this tacked on if they are unable to afford health insurance. For example, a family living with commons debts like student loans, credit card debt, or already outstanding medical fees may be able to pay for this penalty, but only at the cost of having to postpone payments on these debts. From all of this, we can conclude that the Affordable Care Act indeed helped the overall situation of affording healthcare, but it still is not perfect as it has done harm to others who originally could not afford healthcare anyways.

While the Affordable Care Act represents the kind of sweeping change that would have the largest effect on healthcare affordability, it does not represent an all encompassing solution to SES health disparities. On a smaller scale, possible solutions include giving a tax break or
reduced payment to patients who choose to undergo experimental treatment rather than standard treatment, assuming such treatment has been proven successful in laboratory settings and is approved for consideration with humans. This would not only provide a cheaper alternative to traditional medication, but help further the medical field in turn. Following from this, an increase in expenditure on medical research from the healthcare budget could allow for innovations in existing technology that would shift the cost of treatments downwards as they become simpler to enact. Lastly, a simple tax hike on the uppermost earning citizens would provide substantial benefits if the money was put towards lessening the out of pocket costs of patients at hospitals.

Lastly, we can look at possible solutions for the issue of social status having a negative impact on patient-doctor relationships. While this is an equally important issue, it is much more difficult to deal with as it is not something that can be easily measured nor is it easily enforced by law like insurance is. Instead, this issue must be addressed by society itself. While not as prevalent as in the era of Parsons and Bourne, social class still carries a stigma that alters others’ perception of an individual, whether for good or bad. In many ways, this stigma cannot be specifically changed on its own. However, by solving the issues present in providing healthcare to the underprivileged, we are also affecting the perception of the lower class in medicine. If more and more of the lower class are seeking medical aid, they will become more knowledgeable about how many of the systems present work, how to address physicians and interact with them, and in turn will be seen as more common patients rather than a rare outlier. With an increased rate of treatment, as well as following such treatment when it is no
longer a financial liability to do so, doctors will form bonds with their patients and be more accepting of engaging in a mutualistic relationship with them.

The Peck and Conner (2011) study showed that economic class is not the only major factor in patient-doctor interactions, but that gender and ethnicity are also important. While it is possible that some members of these groups might also fall under lower social class, such as poor minorities in urban populations, this is not always the case and must be addressed separately. This problem is mostly due to the disparity between demographics of patients and physicians. Of active physicians in the United States, only thirty percent are female, while 3.3% are black and 2.8% are hispanic, compared to 12.2% and 13.2% respectively in the general population (Association of American Medical Colleges 2006 and 2012). In order to decrease the difference between this predominantly white, male occupation and the demographics of society, we must encourage minorities to pursue an education in medicine. This would be most easily done at an early stage by targeting populations that have higher ethnic diversity with more information on how to pursue a medical career in their future, as well as the benefits of learning about medicine. Furthermore, increase incentives for ethnic minorities and females to attend college and medical school by providing more scholarships to assist in paying for the cost of their schooling. One issue with this plan, however, is that often times these high ethnic populations are in urban areas where primary schooling tends to be poor, leading to decreased student performance later in their education. This makes it difficult to encourage these students to pursue medicine as they may not be able to get into an undergraduate university to begin with, or may not be qualified to enter medical school due to a lack of education despite being given scholarships to remove the financial barrier. As such, much of the issue is due to
the education systems of such areas and cannot be solved alone. Instead, these school districts would have to receive increased funding themselves in order to better prepare and education young minds for higher education. Like with providing funds for lower income health insurance, much of this funding would have to come from taxes, as education funding already does, but be allocated to higher need school systems. This not only helps to address the problem of disproportional representation of minorities in the medical field but in other education-dependent professions as well.

Socioeconomic status is the root of many problems within the lives of citizens of any country, accessibility of medicine being no exception to this rule. Unfortunately, with this being an issue as widespread and all-encompassing as it is, there is no quick fix to providing equal healthcare to all without bringing up many more problems in the process. With legislation like the Affordable Care Act and the inevitable shifting of social stigmas and ethnic representation over generations, we can attempt to address these problems one step at a time. Thus, we must remember to be ever patient if we wish to finally see our goal: to provide a healthy life to all.
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