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Effects of Socioeconomic Status and Race on Access to Healthcare in the United States

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ABSTRACT

This literature review discusses the effects of an individual or community's socioeconomic status and race on their access to healthcare in the United States as important and controversial. Health issues affect all Americans yet inequalities still exist in the healthcare system. Aspects of socioeconomic status and race are prevalent factors in many social problems, especially in their significant influence on access to, quality of, and availability of healthcare that a person receives. The reviewed studies discuss how social stratification regarding socioeconomic status and race lead to disparities in the field of healthcare when discussing the quality of care, health insurance, health status, survival rates, waiting times, and locations of routine care. Being of low socioeconomic status or a minority race inhibits one's life chances regarding healthcare. Based on a variety of studies focusing on both socioeconomic status and race, the results supported my thesis that these variables have a negative relationship regarding access to healthcare when an individual is of low socioeconomic status or a minority race.

INTRODUCTION

In America, access to healthcare has become an issue in everyday society and it is heavily involved and discussed within the political community. Defining healthcare access is complicated, mainly because the construct encompasses dimensions of healthcare availability, affordability, acceptability, and accessibility (Akinyemiju 2013). Healthcare, as it exists, can be defined as the "the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health

professions" (IGI Global 2019). American individuals are defined by culture, and within this culture, a variety of factors function to mold behavior and values, which then have the potential to influence cultural values and beliefs toward health care (Zagaria 2013). While health issues affect all American citizens, socioeconomic status and race heavily affect an individual or community's opportunity to receive access to healthcare. It is difficult to find adequate healthcare without good health insurance and opportune physical location, and as minority races and lower socioeconomic status individuals tend to struggle more than those in higher socioeconomic statuses in other aspects of life they are more likely to have worse access to healthcare.

This power within American society has led to discrimination and lack of healthcare in some areas compared to others, as the American "healthcare system is predicated on the belief that the poor and 'unworthy' of our society do not deserve decent health" (Leon-Guerrero 2019:67). Along with an overarching lack of healthcare access, there is a wide demonstration that stigmas affecting health care experiences include race, class, gender, and illness-status, showing that health care stigma is also associated with insufficient and deferred care, infrequent check-ups, absence of needed tests, faster progression of illnesses, and overall lower quality of life (Martinez-hume, et al. 2017).

Factors such as socioeconomic status and race are aspects that may have an effect on who can receive adequate healthcare and who cannot. Socioeconomic status (SES) is a term used to describe an individual's "social standing or class of an individual or group. It is often measured as a combination of education, income and occupation" (APA 2019). Race, as a social construction, is defined as a grouping based on assumed shared physical traits, ancestry, or genetics, that lack a basis in biology (Leon-Guerrero 2019:52). In American society, these aspects of SES and race are prevalent factors in social problems such as income, life chances,

discrimination, politics, and so much more. This provoked me to ask, does an individual's socioeconomic status and race affect their access to healthcare? When deciding to research this topic, I hypothesized that being of lower socioeconomic status or a minority race would worsen an individual's access to healthcare, making this a negative relationship.

Access to healthcare and the assets that affect it are important in everyday society as it functions in social stratification and may alter a person's life chances overall. America, as a society, has grown to have increased knowledge about available healthcare options, and the differences between them, as well as the advancement in medical preventatives and treatment plans, and therefore have obtained an overall raised standard of living regarding health outcomes (Hegenauer, 2016). For families of lower socioeconomic status, medical expenditures represent a major financial burden that can inhibit families' ability to acquire other goods and services (Charron-Chénier and Mueller 2018). Social scientists hold interest in healthcare and why Americans do not receive the same opportunity or care as other Americans, which encourages them to look into the causes of this phenomenon. In my research, I will examine whether these sociological aspects have a substantial effect on access to healthcare by discussing the variables of socioeconomic status and race and the studies that coincide with them.

SOCIOECONOMIC STATUS

Socioeconomic status (SES), or an individual's social standing regarding education, income and occupation, is an aspect of society that affects the everyday life of an individual within their community. Regarding healthcare, SES affects insurance coverage, income that resolved uncovered expenses, location, familial life, etc. The economic climate of a region in which a person lives determines the availability and quality of employment opportunities, which then lead to a source for health insurance coverage, and also influences the public availability

and accessibility of healthcare resources (Litaker, Koroukian, and Love 2005). Research has shown that significant SES health discrepancies exist in modern society, and in some cases have grown to be more prevalent and influential. For example, “2012 statistics reveal that the leading cause of death for both women and men, heart disease, has an inverse relationship with income level” (Hegenauer, 2016:93). Overall, a higher SES leads to better access to healthcare which promotes a better health status, more frequent use of ambulatory services, and lower hospitalization rates (Ahmed, et al. 2001). In comparison, lower SES individuals suffer higher rates of medical morbidity and premature mortality, while receiving less medical care (Ahmed, et al. 2001).

While having limited access to healthcare, low SES individuals describe a variety of ways in which they felt they had received an overall lower quality of care. In using public insurance, compared to private insurance holders of higher SES, low SES individuals have been subjected to facing different prescription and treatment options, and reluctance of healthcare providers to administer treatment at all (Martinez-hume, et al. 2017). Social status differences in health outcomes are produced again and again over time, due to the fact that privileged groups have exclusive resources, such as money, power, social connections, prestige and demographics, that can be used to avoid risks or minimize the consequences of diseases, while lower SES groups suffer without these resources (Hegenauer 2016). Higher incomes increase and improve the access and use of the medical care system, as they allow for the opportunity and the means to pay for coverage and healthcare. (Durden and Hummer. 2006). Health risks for “marginalized groups manifest through exclusive distribution of information or the lack of means for some to follow the given information. For instance, the knowledge that smoking was detrimental to health didn't reach lower-class individuals as quickly as middle and upper-class individuals, so

they didn't know that it would be beneficial to change habits" (Hegenauer 2016:96). Another example is that women residing in counties with a higher proportion of low-income residents compared with high-income residents had higher hazards regarding breast cancer (Akinyemiju 2013). So, with overall worse health conditions and survival rates, lower socioeconomic status individuals are offered less, if any, healthcare.

Socioeconomic factors such as employment status, income, education, and possession of health insurance are influential factors that have created a system of varying access to care in America (Durden and Hummer. 2006). A common issue resulting from these differences is access to a primary care physician, as 25% of patients visiting the emergency department (ED) at any given time state that it is their usual source of care, and an additional 15%–25% of people being treated in the ED report no source of usual care, defining the ED as their default site of care exclusively (Hong, Baumann, and Boudreaux, 2007). With lower socioeconomic status, individuals often do not have adequate healthcare and must resort to emergency departments for care, while their higher SES counterparts have primary and specialist care. Two SES variables, insurance status and education, were associated with a greater likelihood of routine ED use, the strongest predictor of routine ED use being insurance status (Hong, Baumann, and Boudreaux, 2007). In addition to this lack of qualification and access to primary care, many individuals state that they are unaware of aid programs that may be available to them. Regarding barriers to obtaining healthcare, 6% reported childcare problems, 31% reported taking time off work, and 15% reported transportation as a barrier (Ahmed, et al. 2001). Without access to routine care, individuals are more prone to put off their health problems, as they are not in the place to put off their everyday life to travel to an emergency department and spend an endless amount of time in the waiting room, which then worsens health complications overall.

Waiting times when receiving care within healthcare facilities are largely reliant on SES, as those of higher SES are treated more promptly and adequately. In a study examining waiting times based on socioeconomic inequalities, the researchers found statistically significant differences in waiting times across socioeconomic groups, as "patients living in more income-deprived areas wait longer than patients in less deprived areas that attend the same hospital"(Moscelli, Siciliani, Gutacker, Cookson. 2018:291). In 2002, patients who were most deprived, or of lower SES, waited 53% longer than their counterparts of higher SES, as the gap can be measured to be at least 12% after 2007 (Moscelli, et al. 2018). Waiting time based on inequalities within hospitals tend to be more largely gapped when involving life-threatening conditions like coronary heart disease, compared to conditions that are not considered life-threatening such as osteoarthritis, which can be treated by a more simple, low-risk hip replacement surgery (Moscelli, et al. 2018). These differences based on socioeconomic inequalities are economically meaningful and statistically significant as the health of lower SES patients endure waiting longer for the same condition, compared to higher SES patients (Moscelli, et al. 2018). Based on the results and studies of various researchers, the hypothesis that low SES negatively affects healthcare access and benefits, is supported by the evidence provided.

RACE

Race is a prevalent factor in determining access to healthcare in America. Based on race, minorities tend to have less, or worse healthcare access compared to their white counterparts. Research has shown important racial disparities in access to health care (Charron-Chénier and Mueller 2018). Racial and ethnic minority group members are likely to find work in unstable and low-wage employment which ties in low SES, and these jobs often involve exposure to health-

harming workplace conditions, and do not provide the financial means to access healthcare (Calasanti and Giles 2018). Residents of segregated minority neighborhoods are less likely to have access to primary care providers, healthcare services, and products.

As low SES minority groups suffer from a lack of adequate healthcare, they also face the mentioned stigma associated with a lack of insurance. Due to this stigma, prescription drug use is lower for black communities partly because the physicians resort to prescribing differential drugs, due to a sense of mistrust and prejudice, which is ultimately harmful to the patient's health as some medications could be necessary as treatment (Charron-Chénier and Mueller 2018). These racial and ethnic minorities are overrepresented among the poor population of America, and as public insurance beneficiaries, they are likely to be stigmatized in the healthcare system (Martinez-hume, et al. 2017).

With an increasingly diversifying population, the foreign-born population of the United States has increased by 57 percent from 1990 to 2000, and Hispanic populations accounted for a large portion of this growth (Durden and Hummer 2006). In American society, since 2002, Hispanic Americans have been noted as the largest ethnic minority group (Leon-Guerrero, 2019:53). Mexican Americans were found to have 30 percent lower odds of usual access to healthcare in comparison to non-Hispanic whites. (Durden and Hummer 2006.) Mexican Americans, Puerto Ricans, and other Hispanics display significantly less access to care than their non-Hispanic white counterparts (Durden and Hummer 2006.) Hispanic adults, regardless if they are foreign born or natively born in the United States, appear to be most neglected regarding access to regular and sufficient healthcare, so naturalization could be an important factor in better access to regular and high-quality care for these immigrants (Durden and Hummer 2006). all Hispanic subgroups are less likely to report access to a regular source of care in comparison

to non-Hispanic whites. (Durden and Hummer 2006.) Hispanics in the southwest were found to have less access to medical care than the general population. (Durden and Hummer 2006.) Due to racist tendencies of American society, being foreign born influences an individual's access to the U.S. health-care system, which is usually tied to the employment commonly secured by immigrants (Durden and Hummer 2006).

Alongside Hispanic Americans, black Americans are also minorities when it comes to healthcare access. Due to a lack of insurance coverage and a primary care physician, black and Hispanic patients are more likely to use the emergency department (ED) for routine care, so respectively, black and Hispanic patients were more likely than white patients to use the ED for routine healthcare (Hong, Baumann, and Boudreaux 2007). As mentioned in the previous section, black women are less likely to survive from breast cancer compared to white women (Akinyemiju 2013). The findings within the study of survival rates of black and white women from breast cancer, suggest that neighborhood poverty and lack of healthcare resources to care might explain part of the black-white disparity in breast cancer survival especially if examined from both individual and neighborhood levels. (Akinyemiju 2013). Breast cancer incidence and mortality rates have declined steadily in the US for the past 10–15 years, but the survival increase in black women has been smaller, as the five-year survival for breast cancer was 90% for white women and 77% for black women between 2001 and 2007 (Akinyemiju 2013). The factors other than race that tie into this breast cancer study are SES, income, location, insurance coverage, and overall access to healthcare. Going off of that, African Americans are nearly twice as likely to be uninsured than whites, and Hispanics are more than three times as likely to be uninsured (Andrulis 2010). Resulting from a lack of insurance coverage, inequalities regarding access to healthcare, and other factors, researchers estimate that the cost of these racial/ethnic

disparities in direct medical costs and lost productivity in the United States, from 2003 to 2006, exceeded 1.24 trillion dollars (Hegenauer, 2016). Seeing the amount of inequality in the healthcare field in a monetary value really displays how much social stratification affects an individual's access to healthcare and quality of care overall. Large gaps were evident in out-of-pocket health spending, including health insurance costs, between blacks and whites at all income levels, and "given blacks' poorer average health status and greater need for medical care, these differences in health care spending are particularly striking" (Charron-Chénier, Mueller 2018:63).

Non-Hispanic whites report receiving more care overall in doctor offices in comparison to Hispanic subgroups and non-Hispanic blacks, as a greater percentage of non-Hispanic whites report a doctor office as their source of regular medical care, while Hispanic Americans have the largest percentage reporting the clinic or ED as their primary source of care (Durden and Hummer 2006). As mentioned in the past section regarding socioeconomic status as an important factor in determining access to healthcare, black and Hispanic patients are commonly of low SES. The black and Hispanic individuals examined in research were 18 through 64 years old, had an educational level of high school or below, had Medicaid insurance or were uninsured, were unemployed, and had an annual personal income of $30,000 or less, which led them to have limited, inadequate healthcare access (Hong, Baumann, and Boudreaux 2007). These aspects of low SES and race can be applied to support my thesis, as both variables heavily influence access to healthcare and are often observed concurrently.

Race is an influential factor tied into healthcare access and when examined in conjunction with socioeconomic status, the results are even more solidified. Minority groups such as black and Hispanic Americans are negatively affected by the American healthcare

system, and minority women are impacted even more. When considering why the inequalities of healthcare throughout America exist, race is a substantial determinant.

CONCLUSION

In American society, access to healthcare is a controversial and problematic issue that affects the everyday lives of Americans. Healthcare access is studied by social scientists as is is integrated into social stratification and the life chances that an individual has based on how they are stratified, as all Americans do not receive the same opportunity and healthcare. Health issues inevitably affect all American citizens, but socioeconomic status and race heavily affect the available opportunity to receive access to healthcare and treatment. In more aspects of life, other than healthcare, minority races and lower socioeconomic status individuals and communities struggle more than those in higher socioeconomic status. As the majority, 96%, of respondents report facing barriers to healthcare, healthcare access is an obvious public issue (Ahmed, et al. 2001.) Within the studies that I read, there is a significant amount of data that supports my thesis. Minority races have less access to routine healthcare, while having worse health conditions and survival rates overall, which supports the idea that being a non-minority race is advantageous in regards to healthcare (Hong, Baumann, and Boudreaux 2007). Regarding socioeconomic status, individuals face many barriers in attempts to receive healthcare, and are often left no choice but to resort to an emergency department with extended waiting times and worse care overall (Moscelli, et al. 2018). While facing more difficult and harmful health complications, lower SES and minority race individuals receive worse, if any, healthcare.

The persistence of disparities in the field of healthcare access, suggests the need for a more universal approach that looks beyond the individual, and is more considerate towards the needs of the society as a whole (Litaker, Koroukian, and Love 2005). The ultimate goal of

healthcare professionals is to have the best possible patient outcomes; but to achieve this goal, these professionals must have an understanding of the culture and language of their patients (Zagaria, 2013). In order to provide quality care to patients from various cultures and backgrounds, health care providers in all fields should strive toward cultural competence. The term cultural competence is important to the purpose and relevance of my research as health issues affect all Americans, but nonetheless there are still disparities in the healthcare field. This term can be defined as "the ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, sexual orientations, and faiths or religions in a manner that recognizes, affirms, and values the worth of individuals, families, tribes, and communities and protects and preserves the dignity of each" (Zagaria 2013). Cultural competence is one of the many reasons why healthcare access is such a thoroughly discussed aspect in the political climate and the concerns of everyday life for Americans.

Through looking at a variety of peer-reviewed articles, I have found that socioeconomic status and race are heavily influential when it comes to accessible, adequate healthcare. As the field of healthcare is very broad, this study could be refined more, possibly looking at healthcare access in a particular city, like Chicago for example, and the effects of redlining and hypersegregation. Issues with healthcare access are also very prominent in the American elderly community, as Medicare is involved and relied on, so this could serve as a further point of study, alongside SES and race. Overall, SES and race can be viewed as impactful aspects of healthcare access across the United States.

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