

# How Socioeconomic Status Affects Patient Perceptions of Health Care: A Qualitative Study

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## Abstract

**Introduction:** Clinician perceptions of patients with low socioeconomic status (SES) have been shown to affect clinical decision making and health care delivery in this group. However, it is unknown how and if low SES patients perceive clinician bias might affect their health care. **Methods:** In-depth interviews with 80 enrollees in a state Medicaid program were analyzed to identify recurrent themes in their perceptions of care. **Results:** Most subjects perceived that their SES affected their health care. Common themes included treatment provided, access to care, and patient-provider interaction. **Discussion:** This study highlights complex perceptions patients have around how SES affects their health care. These results offer opportunities to reduce health care disparities through better understanding of their impact on the individual patient-provider relationship. This work may inform interventions that promote health equity via a multifaceted approach, which targets both providers and the health care system as a whole.

## Keywords

low socioeconomic status, patient perceptions, health care disparities, qualitative methods, primary care

There is evidence that socioeconomic status (SES) affects individual's health outcomes and the health care they receive.<sup>1-18</sup> People of lower SES are more likely to have worse self-reported health,<sup>5,6</sup> lower life expectancy,<sup>7</sup> and suffer from more chronic conditions<sup>8-11</sup> when compared with those of higher SES. They also receive fewer diagnostic tests and medications for many chronic diseases<sup>12-17</sup> and have limited access to health care due to cost and coverage.<sup>18</sup>

Compared with other patients, physicians are less likely to perceive low SES patients as intelligent, independent, responsible, or rational and believe that they are less likely to comply with medical advice and return for follow-up visits.<sup>19,20</sup> These physician perceptions have been shown to impact physicians' clinical decisions.<sup>21-23</sup> Physicians delay diagnostic testing, prescribe more generic medications, and avoid referral to specialty care for their patients of low SES versus other patients. Some physicians believe that tailoring care options to a patient's socioeconomic circumstances can improve patient compliance and thereby improve health outcomes.<sup>22</sup> However, other studies have shown that physicians believe that the financial and coverage restrictions faced by low SES patients limit access to care and results in worse health outcomes for these patients.<sup>22,23</sup> There are also some physicians who do not care for patients of lower SES with publicly financed insurance due to low reimbursement rates.<sup>24-26</sup>

While this body of work has improved our understanding of the impact of SES on physicians' perceptions and practices, there has been little investigation into the perceptions of low SES patients regarding how their SES affects the care they receive. Many studies have shown that individuals of lower SES tend to be less satisfied with their care and face substantial barriers including lack of insurance coverage and unaffordable costs.<sup>27-30</sup> Few studies have investigated whether patients of low SES are aware of the attitudes and practices physicians have been shown to have when caring for low SES patients, and how such perceptions affect the way low SES patients interact with the health care system and their providers. The purpose of this study was to determine if and how individuals of lower SES perceive their care is affected by SES.

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## Methods

Using public insurance as a proxy for SES, patients were recruited to participate in in-depth interviews at the University of Iowa Hospital and Clinics (UIHC) over 2 different 3-month periods in 2013 and 2014. Two different methods were used for patient enrollment: (1) In 2013, all scheduled patients from a clinic devoted to patients enrolled in a state Medicaid program financed through a 1115 waiver from Centers for Medicare and Medicaid Services were invited to participate in interviews. Approximately 90% of the enrollees in this state Medicaid expansion program were living below 100% of the federal poverty level in 2012 compared with a statewide poverty rate of 12.8%.<sup>31-33</sup> (2) In 2014, after statewide Medicaid expansion through the Affordable Care Act, patients with publicly financed insurance could receive care at a variety of primary care practices throughout the state and were no longer required to obtain care through specifically assigned practices.<sup>34,35</sup> Thus, all patients with publicly financed insurance being seen in the main Family Medicine outpatient clinic at UIHC were identified and invited to participate.

The interviews were conducted by a single research assistant trained in qualitative interviewing techniques. Each interview began with asking patients to share their health care experiences in general and was followed by more specific questions related to health care experiences and SES; a full interview guide is available on request. This study was approved by the institutional review board at the University of Iowa.

The interviews were audio-recorded, transcribed verbatim, and entered into an NVivo10 database,<sup>36</sup> for systematic coding and searching of narrative data. Using the “editing style” approach described by Miller and Crabtree,<sup>37</sup> all members of the research team read transcript samples and independently identified key concepts. After comparison, a preliminary coding scheme was developed, which was then applied to all transcripts. Research team members coded a sample of transcripts and compared codes in order to generate a more final coding scheme to be applied to all transcripts and to identify salient, consistently occurring themes of patient perceptions.

## Results

Subjects (N = 80) included 47 women, 9 patients from minority racial backgrounds, and 50 patients who had private insurance previously (see Table 1). This level of racial diversity is reflective of Iowa’s statewide demographics.<sup>38</sup> In addition, a majority of subjects had been enrolled in the program for over a year.

The main finding of this study was that most subjects perceived that their SES did affect their health care experiences, though they varied in how they experienced the

**Table 1.** Subject Characteristics (N = 80).

Female, n	47
Age range, years	21-63
Race, n	
White	70
African American/Black	7
Other	3
Education, n	
Some high school	10
High school graduate	27
Some college	31
College graduate	12
Marital status, n	
Single	27
Married	26
Divorced	20
Widowed	5
Separated	2
Employment, n	
Employed	26
Self-employed	8
Homemaker	5
Looking for work	15
Not looking for work	7
Retired	2
Unable to work	17
Previous insurance, n	50
Length of time on public insurance, n	
<1 month	7
1-6 months	10
6-12 months	21
>1 year	42
Health quality, n	
Poor	9
Fair	37
Good	30
Excellent	2

impact. We identified 3 main themes representing the range of patient perceptions of how SES affects health care: (1) treatment provided, (2) access to care, and (3) patient-provider interactions (see Table 2).

### Complex Perceptions of Care

The majority of subjects resisted directly stating that their SES influenced their care. While many of them said directly that there was no difference between the health care they receive and the health care higher SES patients receive, most of these subjects later indirectly implied that there was a difference. For example, one subject said, “I don’t feel as if my private insurance made a difference from my cheap insurance. They don’t treat me any different.” However, later in the same interview, this subject said, “You don’t get as many

**Table 2.** Themes of Patient Perceptions and Example Quotes.

<i>Theme 1: Impact on treatment provided</i>	
Limited coverage for testing	“I’ve had things where the insurance company wouldn’t cover it so I’ve had doctors work around it to still help me get what I need but then there’s some doctors that say, ‘well your insurance company won’t cover it, so we can’t do it’. In those cases, there may be things going on that they don’t discover because they aren’t running the proper tests.”
Long waiting times for testing	“With certain insurance companies, if you got like a first-class insurance company, you’ll get in anywhere like that. But like if you got anything other than first-class insurance, then it’s gonna take a minute . . . I’ve been having to wait 3 or 4 months (for tests). If I had the right insurance, I would have been able to take those tests right away.”
Brand name vs generic	“They say there’s no difference between regular medication and generic medication but there is. If I’m on low income, I get the low-grade medicine, not the stuff that probably could really work.”
Less unnecessary testing or expensive medications	“When I had private insurance, it seemed like there were an awful lot of tests done. I’m not sure all of them were absolutely critical.” “I like when they’re willing to look at generics and samples and that type of thing. They don’t wanna add more stress because that just impacts health in a huge way.”
<i>Theme 2: Impact on access to care</i>	
Cost barriers	“Deciding whether or not you need to go see a doctor when you are sick if you don’t have insurance is the hardest decision. I face that every day. Do I go? Do I not? What’s the bill gonna be like?”
Time barriers	“It’s the length of time it takes to get an appointment here. Sometimes it can take 3 or 4 months. That’s why a lot of times if I have something, I have to go to the emergency room because I couldn’t get in.”
Acceptance barriers	“The problem has always been trying to find someone to accept the [public] insurance health care. It’s like, okay, Dr. Smith will take it but Dr. Jones won’t and now I need to find a certain type of doctor or specialist that takes that insurance.” “With private insurance, we had to pay the deductible of course, but we were free to choose where we wanted to go. . . We were free to choose everything and now we’re not.”
Thankful for access to care	“I am just grateful to have it. Even if there are restrictions, at least you’re taken care of. People like me wouldn’t be getting medical care if it didn’t exist”
<i>Theme 3: Impact on patient-provider interaction</i>	
Provider attitude toward patients	“Oh yeah they know [about my SES] but they don’t ask about it. I’m sure but they don’t treat you any different. I figure they’re in the field because they want to help people” “If you go in there and you got lots and lots of money, their attitude toward you is a lot different than if you go in there and you’re low income”
Provider knowledge of patient coverage	“They know what’s covered and what’s not and they decide what they need to do. . . I don’t think it means I’m getting less care. . . I think it just affects it as far as they know what will be covered and what won’t. And they try to make sure it’s covered.”
Provider communication	“They talk to you like you’re not a doctor which they need to do because we’re not doctors. They talk to you in terms that you would understand without making you feel like you are beneath them.” “I don’t think the doctors listen to you the same as if you were a paying customer or if you had different insurance. It’s like you say something and they just kinda skip over it and ignore you.”

tests as you do when it’s private so I’m still working off the same x-rays from last year.” In some instances, subjects said that SES affects health care for many individuals but not for them, since they were experienced with the health care system and determined to not be treated differently.

### *Impact on Treatment Provided*

Most subjects reported that their SES had some impact on the treatment they received. Examples of this included perceptions that SES influenced the number, type, and

scheduling of diagnostic tests that physicians performed. Because of high costs (eg, magnetic resonance imaging), subjects thought that the testing they were eligible for was limited; this was interpreted as reducing the amount of diagnostic information available to their provider. Subjects also perceived that their SES lengthened the time required for these tests to be approved, which slowed diagnosis and treatment. Similarly, many subjects perceived that their SES affected the types of medications that physicians prescribed. While many thought that generic medications were equal in quality to brand-name medications, there were

several patients who thought that generic alternatives were less effective and did not like when physicians prescribed them.

In contrast, some subjects felt that the difference in testing and medications actually improved the quality of health care they received since under private insurance they felt they received unnecessary testing and expensive brand-name medications. A few even asked their physicians to prescribe generic medications and limit testing.

### *Impact on Access to Care*

Though some subjects indicated that they faced no cost, time, or distance barriers to access, a majority of subjects thought that their access to care was worse as a result of their SES. Many subjects described situations in which they delayed or avoided seeking care because of cost, which typically only resulted in worsening of their conditions and an even more expensive hospital visit.

Subjects also described the challenges they faced in finding providers who were able and/or willing to care for them. The limited number of physicians and hospitals treating patients of low SES indirectly created distance and time barriers, which discouraged them even further from seeking care initially. Patients at times had to drive over an hour to find hospitals that would treat them and some had to wait several months to get an appointment with a primary care provider. These barriers made it especially difficult for those who could not afford to pay for gas, lacked reliable transportation, or required emergency treatment. However, despite these sentiments, many subjects also expressed how grateful they were that they had access to care at all.

### *Impact on Patient-Provider Interaction*

While almost all subjects indicated that their physicians were aware of their SES, they differed on whether or not that knowledge affected how their physicians cared for them. Many subjects perceived that their SES had no impact on the way they were viewed and treated by their physicians and that they had a good relationship with their provider. For example, subjects appreciated that their physicians understood the economic constraints and were knowledgeable about what was covered under the publicly financed program. In terms of communication, subjects thought that their providers explained things thoroughly and answered all their questions; they appreciated how doctors tailored communication to meet their personal needs.

In contrast, some subjects perceived that physicians viewed and treated them differently because of their SES. Frequently reported differences in patient-provider communication included situations in which providers did not listen to what they were saying or answer their questions. Subjects used a variety of negative words and phrases to

describe how they perceived their doctor viewed and treated them because of their SES, including: a *customer*, *on the back burner*, *bottom feeder*, *bum*, *another cog in the wheel*, *dollar bill*, *leech*, *livestock*, *a number on a file*, *peasant*, and *scum*. Whether or not providers actually viewed and treated these patients in such a manner, subjects noted this perception caused them to feel ashamed of themselves and hesitant to return for care.

## **Discussion**

Most subjects within our sample believed that their SES influenced the health care they received. The complex answers subjects gave to these questions suggests that while our subjects were able to acknowledge that SES influences health care for patients in general, many had difficulty expressing or were reluctant to say that their own personal health care or providers' perceptions of them may be inferior because of their SES. This mirrors the findings in the physician studies; while physicians do as a group perceive and treat low SES patients differently than those of high SES,<sup>19-23</sup> it may be difficult to identify themselves as contributing to such disparities as they are often unaware of their own implicit biases.<sup>39-41</sup>

Subjects described several aspects of their health care—treatment provided, access to care, and patient-provider interaction—which they perceived to be affected by their SES. While in some instances, differences in these aspects, such as fewer tests performed and expensive medications prescribed, improved subjects' perceptions of the quality of health care they received, the majority perceived that these differences worsened the quality of health care they received and contributed to health care disparities.

Patients' perceptions that such differences in care exist due to SES can potentially contribute to health care disparities. Whether or not the limited number of diagnostic tests and the longer length of time required for their approval actually worsened health care quality, the perception that their care was somehow inferior often caused them to lose trust and confidence in the health care system or their provider. Similarly, whether or not generic substitutes are truly less effective than brand-name medications, the perception among these subjects that they are, in fact, inferior could potentially worsen health care outcomes if it leads to non-compliance with the purchase or use of medications as prescribed. Likewise, the perception that physicians view them as "second-class," as described by subjects, could worsen health care quality if it leads to lower likelihood of disclosure of important issues or attendance at follow-up appointments. Perceived health care disparities like the ones mentioned above and those related to access in particular, even led some to avoid or delay seeking health care altogether.

Consistent with previous studies that described low SES patient perceptions of health care experiences, subjects in our study described similar barriers to health care access and areas of dissatisfaction with their health care. However, instead of simply confirming the disparities that exist between low and high SES individuals at the population level, our study expands on the existing literature by exploring if and how low SES patients perceive this disparity to affect their health care. Our findings suggest that subjects are, in fact, conscious of the differences that exist between them and high SES patients in terms of the care they receive and can potentially exacerbate these disparities.

Advancing health equity for low SES patients will require a multifaceted approach that targets both providers and the health care system as a whole. Educating physicians about the implicit biases they may have—and how patients may perceive these biases affect their health care—could help to reduce these disparities<sup>42-44</sup> as it has been shown that physicians change their clinical decisions when they become aware of their unconscious bias.<sup>44</sup> Regardless of physicians' attitudes toward individuals of low SES, providers should be aware of how patients perceive they are treated based on SES, allowing for increased empathy with patient's experiences and identification of potential perceptual barriers to both satisfaction with and adherence to effective health care management. Policies that increase Medicaid reimbursement rates and induce more hospitals and providers to accept patients with publicly financed health insurance could also help reduce health care disparities. Many of the perceived access barriers that subjects experienced in our study, including distance and time barriers, stemmed from the number of providers and hospitals who did not accept patients with such insurance. Recently, the Medicaid Parity provision of the Affordable Care Act increased Medicaid reimbursement rates to at least Medicare levels for 2013 and 2014 in all states with the goal of increasing the number of providers who accept Medicaid patients.<sup>45-47</sup> It was thought that, by expanding this number, patients would be able to seek health care closer to home, reducing the travel costs and wait-times for primary care appointments. One study found that the Medicaid Parity provision increased primary care appointments by 7.7% and that the states with the largest increases in availability were those with the largest increases in reimbursements.<sup>47</sup> Despite its effectiveness, the policy expired at the end of 2014 and was not extended.<sup>48</sup>

Limitations to this study include it being conducted with a patient population in one geographic area, limiting its generalizability to other settings and populations. Also, the tendency to remember negative experiences more than positive experiences may have skewed patient responses to interview questions and also affected those who chose to participate in the study. Finally, the study was conducted during a time period of many changes in health care

delivery and at 2 sites that differed in the types of coverage that were accepted, the appearance of the clinic, the providers at the clinic, and the location of the clinic in the academic health center. These factors could potentially affect how patients perceived their health care experiences and further influence our results. Bias was limited by asking participants not only about their current experiences but also about their past experiences (including experiences at other hospitals).

Areas for future research include investigating how patient perceptions are affected by the severity and type of medical condition for which they are receiving care. For example, though we did not collect data on the purpose of the subjects visit, several subjects in our sample felt that their SES did not affect their health care because they did not have a serious enough health condition for it to make a difference. It is possible that perceptions might differ between a low SES patient who is receiving care for a cold when compared with a low SES patient who is receiving care for cancer, for example. Comparing appointment lengths under private and public insurance coverage and exploring how differences affect patient perceptions might also be interesting.

Our findings identify a range of patients' perceptions regarding their SES and health care experiences. Most subjects perceived that the treatment provided by their physicians, access to health care, and the relationship they had with their provider were affected by their SES, though they often avoided saying so directly. Reducing and eliminating health care disparities is a complex, multifactorial endeavor that will require complex solutions, but increasing physician awareness of implicit biases, patients' perspective and experiences, and improving access to care through the expansion of Medicaid and related programs may be beneficial in advancing equity and patient perceptions of equitable treatment. Further investigation into how patient perceptions of physician bias impact care of low SES populations that have received health care coverage due to the Affordable Care Act will be helpful informing these questions.

### Authors' Note

The views and findings discussed in this article are solely those of the authors and not the University of Iowa.

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