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Research Article

Health Care Experiences of the Poor in One Texas City

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Access to healthcare is an important issue in the United States. The purpose of this study was to explore ways in which individuals living under the federal poverty line experience negative interactions with the health care system. Eleven individuals were interviewed in the Waco area who are currently living under the federal poverty guideline. Answers were recorded and analyzed. Common themes amongst the participants included (1) financial insecurity combined with a lack of health insurance discouraged individuals from visiting a healthcare provider, (2) inadequate transportation to a healthcare establishment, (3) feelings of disrespect when receiving treatment from healthcare professionals, and (4) difficulty following up with treatment. In conclusion, the problems that arise in the healthcare system regarding the treatment of individuals living in poverty cannot be attributed solely to lack of funds.

Keywords: Healthcare; Poverty

For those who are struggling to pay the bills from week to week, a trip to the doctor for a cold remedy is just not feasible. A parent's decision to feel under the weather in order to have enough money to pay for a roof over their kids' heads is a sacrifice that many living in poverty have had to make many times. Whether due to overwork, poor nutrition, sub-par living conditions, or a combination of factors, people living in poverty have poorer overall health as compared to those living in the middle or upper class [1][4][5][7][8]. This can be seen in accounts including chronic pain, migraine headaches, and stomach pain, to name a few [7][8][10]. Consequences can also be seen in the decline in mental health among those living in poverty [4][7][8][11].

For example, the life of a single mother living in poverty. She is the sole provider for her children and works multiple jobs take care of her children. She juggles work, being a parent, and trying to keep her kids in school and off the streets so that they can hopefully get out of the current situation one day. Add to that a possible history of abuse, be it substance abuse or physical/emotional abuse from a previous relationship, and all it takes is one unexpected injury, a speeding ticket, or car trouble, to throw off her delicate tightrope walk. Without the car she has no way to get to work on time so she doesn't get paid, her kids don't eat and in a week they will not have a place to stay. All it takes is one unexpected expenditure to cause this mother's life to spiral towards destruction. These situations, magnified through the lens of poverty, can and do lead many to hopelessness which manifests itself in stress, anxiety, depression, and substance abuse [5][7][8][11]. The 45 million people considered to be impoverished in the United States have a predisposition to be in poor health.

Even though many people living in poverty suffer from conditions such as anxiousness, depression, headaches and stomach complaints, many do not see it as either necessary or practical to visit a physician. Many outsiders attribute this attitude merely to the cost of health care. This study focuses on whether the health care system as a whole is structured in a way that predisposes those living in poverty to have negative experiences. An in-depth survey was conducted with 11 low-income patients in the Waco area. The results of the study found that lack of funds, inadequate transportation, having feelings of poor treatment by health care providers, and not being able to follow through with the treatment given by a physician all contribute to how those living in poverty negatively experience health care.

Literature Review

Research shows that there is a strong correlation between low income and poorer quality of health [11][5][1]. These correlations can stem from a variety of factors such as poor nutrition, inadequate sanitation and water, and insufficient access to healthcare [1][5][9]. In order to quantify the relative degree of sickness between socioeconomic levels, researchers look at relevance of specific diseases in low income areas, as well as relative mortality rates. Studies have shown that income inequality correlates to an increased rate of certain diseases. In their study on social capital and healthcare, Holtgrave and Crosby linked four different infectious diseases, including AIDS, to income inequality [10]. There is an upward trend of mortality rates among low socioeconomic status individuals when analyzing mortality rates in socioeconomic levels [7][8].

Even though those living in poverty are ill more often than those living in the middle class, they are less likely to visit a physician [2][6][11]. This could be due to a variety of factors, which can overlap, including lack of health insurance, cost medical expenses, and being able to access services effectively [2][5][6][9][11]. According to research on U.S. children, those living in poverty are less likely to have a primary care physician, health insurance, or dentist, compared to children living in middle and upper class households [2][6][11]. Lack of expendable funds along with the high cost of healthcare also deter individuals living in poverty from visiting a healthcare professional [5][9]. The cost of healthcare can be heavily reduced by obtaining a health insurance package, however research shows that individuals living in poverty are far less likely to be covered [2][9][11]. Access to care is another area in which those living in poverty are negatively affected by [5][6]. Factors that hinder a person living in poverty to access the resources and services available in the healthcare field include financial barriers, barriers regarding the utilization of resources, and equity barriers [1][5][9]. Gulliford and Morgan found in their study of Access to Healthcare that the utilization of services as well as the equity of those services heavily contribute to poor

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access of care for those living in poverty [9]. In areas that have a high poverty rate, there was marginal access to needed services, such as psychiatry [9].

When those living in poverty do go to get treatment, they receive disproportional treatment when compared to the treatment received by those in the middle and upper class. One example of this varied treatment can be seen in the disproportional prescribing of low-cost generic drug programs (LCGP) to those who are low-income, uninsured, or who have Medicare [3][12][13]. Brown, Pauly, and Talbert studied the predictors of the use of LCGP and found that a large portion of people living with Medicare or who are uninsured are likely to use LCGP [3][12]. Although there is an obvious cost benefit to using LCGP [15], some studies show worsening of the patient's condition after the switch to generic drugs, as well as some unintended side effects [16]. These factors, along with a general distrust of the medical system, have led to those living in low-income situations to disapprove of LCGP according to a study by Keri Sewell [14]. Even with the cost benefit, prescribing LCGP to patients living in poverty is still a cause for discourse.

These multiple factors that link poverty to poor health negatively affect not just one's physical body, but also social interactions. Stress is an unintended side effect when an individual living in poverty goes to receive medical treatment, due to influences such as financial instability [5]. The stress that comes from loss of income, job insecurity, and unexpected expenditures leads to fractures in one's home life as well as overall social dissonance [5]. Due to these underlying effects of receiving healthcare, Corbett found in her study of Poverty and Sickness that going to see a healthcare professional places familial and societal strain on individuals living in poverty [5].

Those living in poverty are at a greater predisposition towards ill health, however they are less likely to visit a physician. When they do visit a healthcare provider, they receive disproportional treatment compared to those in the middle class, and often leave with stress that puts strain on their family as well as social relationships. This study will expand on previous research by incorporating the personal experiences of 11 Waco natives who are currently living in poverty. The purpose of this study is to see if the trends of poor healthcare experienced by those living in poverty are seen in the city of Waco, which has double the poverty rate when compared to U.S. cities of similar size. Responses regarding the participants' experiences within the healthcare system will be analyzed in order to compare and contrast with previous research on the topic.

Methodology

Over the course of October and November of 2016, 11 individuals living in the lower class were interviewed about their experiences in the healthcare system. Their current income fell under the federal poverty guideline, which for a household of four was $24,300 for 2016. The sample of individuals interviewed was gathered from Church Under the Bridge, a church for the Waco homeless population. The 11 participants included 5 men and 6 women. Their ages ranged from 41 to 68, with their mean age being 56. Of those interviewed, 5 were white, 3 were Hispanic, and 3 were African American. Seven of the individuals were either married or in a committed long-term relationship. Of the 11 participants, 3 were homeless, 4 lived with a relative or friend, and the other 4 individuals rent either a house or apartment. Six were currently unemployed, 4 were working one or more part-time jobs, and 1 man was employed full time. Pseudonyms are used for all of the individuals quoted to protect confidentiality of participants, and participation in the research was voluntary. Participants were selected at random out of the Congregation at Church Under the Bridge, and could terminate the interview anytime. The interview had five questions: Where do you go to receive medical treatment? Do you have a primary care physician? Have you ever been denied care from a medical facility? Do you feel like you receive the treatment you need from medical professionals? (Why or why not?). Follow up questions were asked as needed in order for the interviewee to expand on their answers. The interviews lasted approximately between 15 and 20 minutes, and responses were recorded and analyzed.

Findings

Of the 11 people interviewed, 7 reported two or fewer visits to the doctor in the past year. Of this group, when asked a situation when they would visit a physician, the following themes of 'when I get time', or 'whenever it's an emergency' emerge from the responses. For Cynthia, a single mother of three who works up to three part-time jobs in a single week, she expresses the inability and fear of loss of job to get off work in order to get treated. "I make minimum wage working three jobs a week in order to put food on the table for my kids," Cynthia explained. "If I take off time to go to the doctor, that's money that's not going to the bank, you know? That's money that I can't afford to lose. That's money that I try to put away for my kids, so that one day they won't have to live like this no more." Cynthia explains how she is afraid to take off because of the lack of security in her income. She also fears that if she takes off too much time, she will be replaced by someone who will not miss work. For the four people who reported visiting a physician multiple times a year on a scheduled basis, three were considered disabled, and therefore receive treatment for their disabilities funded by the government. Julia, a middle aged, homeless woman who suffers from depression, anxiety, and bi-polar disorder, is able to visit her psychiatrist every Monday. "It's almost a blessing," Julia exclaims, "without having a mental health problem, I don't know what I would do." Because of her mental disability, she is able to receive full medical treatment, as well as access to a psychiatrist, which she says saved her life. She says that because of her disability, she is able to receive treatment that, otherwise, would have led to her taking her own life. The final individual, a retired sailor in the U.S. Navy, receives benefits from the Veterans Affairs Hospital in Waco.

Another common reason for not visiting a physician was due to access and transportation to a health care provider. Five out of the seven who rarely visit a physician reported how simply getting to hospital or clinic was a feat in itself. For those who do not have a private form of transportation, the options included walking or riding the bus. For those interviewed who elected to walk, all were currently homeless and unemployed, and therefore could not afford a bus pass. Some individuals exclaimed how, in order to get to the doctor, they have to walk up to two miles to get to their respective healthcare providers. For those who choose to take the bus, a

common struggle arises from trying to match the bus route schedule along with their work schedule. A female participant explained her process for getting from work to her healthcare provider:

> "It takes me 15 minutes to walk to the closest bus stop from my work, then 30 minutes to reach the stop closest to the [Clinic], then another 15 minutes to walk from that stop to the building. So that's an hour I'm not working right there, then I have to sign in and wait an hour to get called back to the room. Then I wait for the doctor to come in and see me, which takes some time. Then after he sees me I walk back to the stop, and, depending on when I get there, have to wait for the bus to go around its' route and get back to pick me up."

She explained to me that, on busy days, it can take up to five hours for her to visit the doctor's office.

Five out of the 11 people interviewed had some form of health insurance benefits. Three, of these individuals have some form of a disability and are therefore covered by the government, that being from either Medicare or Medicaid. One man receives benefits from his time served in the U.S. Navy. The other individual pays for a privatized healthcare package out of pocket. For those who receive healthcare benefits from the government, there was overall satisfaction in the coverage, where most of their health needs were either completely covered or heavily discounted. For the four individuals interviewed who are currently employed, none of their employers provide any form of health insurance package. The common reasons that arose from the group of people who do not have insurance was that they would either not be able to pay for it, or that they were afraid that pre-existing conditions would allowed insurance companies to deny them coverage.

Two major health care centers were named by individuals when asked where they normally go to see a physician: Baylor Scott and White Medical Center-Hillcrest and the Meyer Center Community Clinic. The Meyer Center Community Clinic is an inner-city non-profit health care provider which meets the needs of those living in poverty by accepting patients with no health insurance at minimal cost. The Hillcrest Medical Center is a mid-sized hospital located approximately 15 minutes outside of Waco by car. When asked if they were to visit a physician today, six of the 11 said they would go to the Meyer Center, four said they would go to Hillcrest, and one man would go to the VA hospital. Every person who goes to the Meyer Center as their primary health care provider reported being very satisfied with their experience there. Common responses were that they felt respected, cared for, listened to, and they received adequate explanation for the treatments the doctor recommended. Due to the scheduling of the Meyer Center, doctors rotate in and out of the facility every three months. Even though patients are not able to form a lasting bond with their physician, there was overall satisfaction with the treatment received at the Meyer Center.

For those who receive treatment from Hillcrest, responses were mixed when asked about how satisfied they were with their experience there. "It really depends on the day," Another subject, a middle-aged woman who pays out of pocket for health insurance, told me. "Sometimes I see doctors who are pretty good, and sometimes I get guys who are pretty bad." When asked to expand on what makes some doctors she sees "pretty bad", she said she felt disrespected, like she was being talked down to, as well as feeling dehumanized. She said that some treat her just as a name on a sheet of paper and not as an actual person. "It's like they take one look at me and try to get me out and to the next one as fast as possible." She also commented on how other health care professionals such as nurses, receptionists, and medical students tended to negatively affect her overall health care experience, along the same lines of disrespectful behavior.

> A significant portion of the individuals interviewed expressed difficulty in following through with their respective treatments. Another participant explained how it is difficult for her to take her arthritis medicine correctly.
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> "I have my medicine for my arthritis that I have to take four times a day. I work labor jobs so I can't drop everything to stop and take my medicine so I try to take it on the bus on the way to my second job but I have to take it with something to eat which makes it even harder."

Whenever the doctor finds out that she hasn't been taking her medicine properly, she says, they assume that either she is not responsible or intelligent enough to correctly take her medicine, or that she doesn't want or care to get better. Because of this, she is afraid that doctors will label her as 'noncompliant' and be more apt to turn her away or switch her to medicine that might not work as well.

Six of the 11 interviewees reported feeling stressed and anxious in preparation of their visit to their healthcare provider Whether coming from complications in ability to visit a physician, having feelings of poor treatment by health care providers, or not being able to follow through with the treatment given by a physician, a majority or those interviewed see their healthcare as stressful and anxiety inducing.

Conclusion

The purpose of this study was to explore ways in which individuals living under the federal poverty line experience negative interactions with the health care system. Previous research finds that individuals living in poverty are overall less healthy than those living in the middle class. This can be due to many factors such as poor nutrition, living conditions, and less frequent visits to a healthcare provider. This study was done to investigate if the healthcare system as a whole places those living in poverty at an unfair disadvantage when it comes to promoting healthy living.

The responses collected provide a snapshot into the lives of those living in poverty regarding their experiences with the healthcare system. Paying for medical treatment was a common reason for not visiting a physician. Due to the lack of personal transportation, a majority of the participants found it incredibly difficult to get to a healthcare provider. One woman reported that visiting a physician can be up to a five-hour time commitment. None of the participants received health insurance benefits from their employer, so they have to acquire a policy through different means such as claiming

disability, applying for Medicare/Medicaid, or paying out of pocket. Individuals received care from two major providers: Hillcrest Medical Center and Meyer Center Community Clinic. Those who visit the Meyer Center reported being very satisfied with their overall experience, where as those who visit Hillcrest saw mixed results. Several individuals commented that, due to their erratic schedule, it was difficult for them follow up on the treatment prescribed to them by their healthcare professional. A majority of the participants stated that going to see a healthcare professional was a source of stress and anxiety in their lives. Due to the vast array of responses given, the problems that arise in the healthcare system regarding the treatment of individuals living in poverty cannot be attributed solely to lack of funds.

Limitations in this study can arise from the sample of individuals who participated in the survey. Due to the small sample size (11), variability can arise that skews the results of this study when compared to the entire U.S. population. Another limitation is that the individuals interviewed were all chosen based on their affiliation to Church Under the Bridge. The sample does not represent the population as a whole. An additional limitation to this study comes from the nature of the study. When dealing with a person's health, their emotions can be heightened when faced with poor news. Due to this, responses of how one had a negative experience with a healthcare professional may be exaggerated.

Future studies should be conducted to compare the population in this study to those living in different areas, as well as living in a different economic class. An expansion of this study can ask if the problems seen in the healthcare system are region specific. One could format a study similar to this one, but interview individuals living in a different city, state, or country, to see how the issues of poverty in the healthcare system compare and contrast among those living in different areas. Another area in which future studies can expand is by altering the sample of individuals interviewed to those living in the middle class. Having a bad experience with a healthcare professional is not seen only in individuals living in poverty, so future exploration can see how the issues seen in the healthcare system are universal or economic-class-specific. One could answer the question of if the issues brought up in the responses collected in this study are solely due to poverty, or if there are similarities of pitfalls in the healthcare system across the board.

References

[1] Wagstaff, Adam. Poverty and health sector inequalities. *Bull World Health Organ*. 2002, vol.80, n.2, pp.97-105.

[2] Shi, Leiyu, and Gregory D. Stevens. "Disparities in Access to Care and Satisfaction among U.S. Children: The Roles of Race/ethnicity and Poverty Status." *Public Health Reports* 120.4 (2005): 431–441. P

[3] Brown, Joshua D., Nathan J. Pauly, and Jeffery C. Talbert. "The Prevalence and Predictors of Low-Cost Generic Program Use in a Nationally Representative Uninsured Population." Ed. Keith A. Wilson. Pharmacy 4.1 (2016): 14. PMC. Web. 21 Mar. 2018.

[4] Shaw, David. "Social determinants of health." *Clinical Medicine* 8.2 (2008): 225-226.

[5] Corbett, Jane. "Poverty and Sickness: The High Costs of III-Health." IDS Bulletin 20.2 (1989): 58-62.

[6] Conrad, Peter. *The sociology of health and illness*. Macmillan, 2008.

[7] Marmot, Michael, et al. "Social inequalities in health: next questions and converging evidence." *Social science & medicine* 44.6 (1997): 901-910.

[8] Gottfredson, Linda S. "Intelligence: is it the epidemiologists' elusive" fundamental cause" of social class inequalities in health?." *Journal of personality and social psychology* 86.1 (2004): 174.

[9] Gulliford, Martin, and Myfanwy Morgan, eds. *Access to health care*. Routledge, 2013.

[10] Holtgrave, David R., and Richard A. Crosby. "Social capital, poverty, and income inequality as predictors of gonorrhoea, syphilis, chlamydia and AIDS case rates in the United States." *Sexually transmitted infections* 79.1 (2003): 62-64.

[11] Kataoka, Sheryl H., Lily Zhang, and Kenneth B. Wells. "Unmet need for mental health care among US children: Variation by ethnicity and insurance status." *American Journal of Psychiatry* 159.9 (2002): 1548-1555.

[12] Pauly, Nathan J., Jeffery C. Talbert, and Joshua Brown. "Low-Cost Generic Program Use by Medicare Beneficiaries: Implications for Medication Exposure Misclassification in Administrative Claims Data." Journal of managed care & specialty pharmacy 22.6 (2016): 741–751. PMC. Web. 21 Mar. 2018.

[13] Federman, Alex D. et al. "Association of Income and Prescription Drug Coverage With Generic Medication Use among Older Adults with Hypertension." The American journal of managed care 12.10 (2006): 611–618. Print.

[14] Sewell, Keri et al. "Perceptions of and Barriers to Use of Generic Medications in a Rural African American Population, Alabama, 2011." Preventing Chronic Disease 9 (2012): E142. PMC. Web. 21 Mar. 2018.

[15] Haas JS, Phillips KA, Gerstenberger EP, Seger AC. Potential Savings from Substituting Generic Drugs for Brand-Name Drugs: Medical Expenditure Panel Survey, 1997–2000. Ann Intern Med. 2005;142:891–897. doi: 10.7326/0003-4819-142-11-200506070-00006

[16] Kwan, P., and A. Palmini. "Association between Switching Antiepileptic Drug Products and Healthcare Utilization: A Systematic Review." Epilepsy and Behavior, vol. 73, 2017, pp. 166-172, SCOPUS, www.scopus.com, doi:10.1016/j.yebeh.2017.05.010.