

Issue Brief: Socioeconomic Status/Class and Public Health

Key Words (4-6)

Poor, Wealthy, Middle Class, Healthcare, Medicare, Medicaid

Description (2 sentences)

The brief will focus upon public health in the United States as it relates to different socioeconomic classes. It will define the effect of healthcare provided to each class and identify the way in which funds are distributed.

Key Points (4-6)

- While mortality rates overall are declining, there is evidence that indicates that socioeconomic inequality in health is a key determinate in population health.
- Public health is distributed unevenly through the socioeconomic classes giving the highest income groups the greatest care and the lowest income groups the least.
- Discrimination against poverty is intentionally dismissed due to a general upper-class bias
- Quality of public health takes precedence over the quantity of individuals covered by the public service.

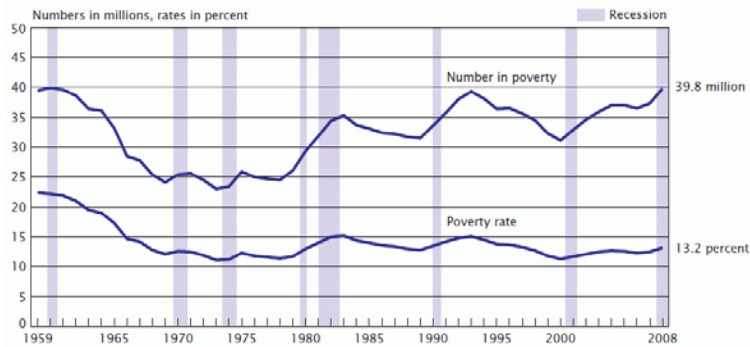
Issue Brief (500-700 words)

The distribution of public health in the United States is greatly skewed. Among the different socioeconomic classes, the poor are the most underrepresented in receiving sufficient healthcare. A significant upper-class bias can be seen in terms of allocation. Services and coverage are abundantly available to those who have monetary influence on the healthcare plan. As the gaps in the classes widen, inequalities become more amplified and the correlation between poverty and low public health becomes stronger. Furthermore, extended or restricted coverage puts pressure on the middle class and blurs class boundaries between middle-rich and middle-poor. The government has attempted to solve the issue through universal programs like Medicare and Medicaid but an unresolved discrimination against the poor continues to aggravate the situation.

In 2008, an estimated 13.2% of the 308, 939,533¹ people in the United States were classified as poor. For the past decade this number has increasingly risen while

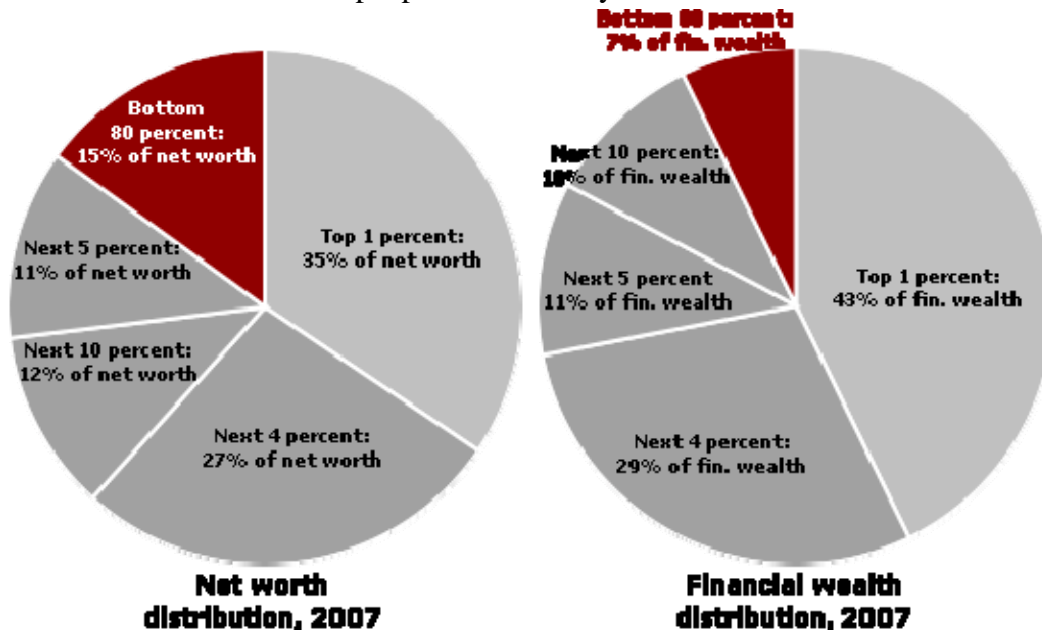
¹ U.S. Census Bureau. <http://www.census.gov/main/www/popclock.html>

Figure 3.
Number in Poverty and Poverty Rate: 1959 to 2008



Note: The data points are placed at the midpoints of the respective years.
Source: U.S. Census Bureau, Current Population Survey, 1960 to 2009 Annual Social and Economic Supplements.

also went up. Also, in terms of net worth, it can be seen that from 2001 to 2007 the rich got richer and the poor got poorer. The top 1% of people increased their net worth by 0.2% while the bottom 80% of people decreased by 0.6%.³ These statistics



⁴ demonstrate the widening of gaps between the socioeconomic classes and lead to an understanding of the main subject matter, public health.

Based on the statistics above, a correlation can now be drawn between public health and socioeconomic status. A CNN report from 2005 stated, “the average family pays about \$2,700 a year for health insurance, not including out-of-pocket expenses for co-payments and prescription drugs,” and furthermore, that the, “National Health Survey conducted by the U.S. Centers for Disease Control and Prevention found more than 40 million people of all ages went without insurance at some point in 2005.”⁵ Interestingly,

² http://upload.wikimedia.org/wikipedia/commons/b/b7/US_poverty_rate_timeline.gif

³ Domhoff, Professor G. William. “Who Rules America?” February 2010.

<http://sociology.ucsc.edu/whorulesamerica/power/wealth.html>

⁴ Ibid.

⁵ Rice, Sibriya. “Poverty and Poor Health are Intertwined, Experts Say.” CNN.com September 2006.

<http://www.cnn.com/2006/HEALTH/08/29/poverty.health/index.html>

the number 40 million is quite close to the number of impoverished Americans. Many individuals who were financially strapped and struggled to pay for basic needs like food, shelter, and cost of living, allowed healthcare to be considered less of a priority. Researchers have also noted that this issue is psychological as well. Specifically, “as salaries drop, individuals tend to be more stressed, and generally lead less-healthy lifestyles,”⁶ which builds a link between income and lower health and less ability to pay for public health. Another account given by the U.S. Department of Health and Human Services detailed, “Poor Americans are significantly more likely than those with high incomes to have health risk factors that include smoking, being overweight, and having a sedentary lifestyle. However, they also use less health care than most Americans and are less likely than the nonpoor to have had a recent physician contact, receive prevention care such as immunizations or cancer screening, or to avoid hospitalization for serious conditions by receiving preventive, office-based care.”⁷ With both these accounts the situation becomes clear that socioeconomic status affects one’s ability to receive public health as well as prevent extended periods of illness that require further attention.

In essence, those of lower socioeconomic status are at a disadvantage for receiving proper healthcare. It is also the American public’s lack of concern for the impoverished minority group that furthers this public health issue. While those who are at the top of the spectrum, controlling most of the nation’s wealth, receive adequate public health services, the lower 20% of the nation must deal with insufficient health benefits and relatively expensive out-of-pocket payments. Additional pressure is also forced onto the middle class who must struggle to pay for their coverage. This causes the middle class to split into the middle-rich and middle-poor classes. Restricted coverage hurts the wellbeing of lower middle class citizens and strengthens the control of the upper class.

Greater health coverage for lower classes needs to be provided to counterbalance the plethora of health issues that come along with lower incomes. The government needs to restructure the allocation of taxes for public health to give an advantage to the poor. While this suggestion is difficult to achieve because of the control the upper class exercises over the public health program, national attention to healthcare as a civil or human right might begin to create a change. Exemplified in European nations where quality healthcare is provided at little to no cost, the United States could readdress this issue as a concern for humanity and engage the upper class to participate further. This would take the pressure off the middle class and aid those in need. Public health inequalities between classes would begin to decrease if this objective was obtained and more individuals would have the opportunity for a better life.

⁶ Ibid.

⁷ Rowland, Diane. “Poverty and Health.” <http://www.answers.com/topic/poverty-and-health>