

END OF LIFE & SOCIOECONOMIC STATUS



SOCIOECONOMIC STATUS

Socioeconomic status (SES) encompasses not just income but also educational attainment, financial security, and subjective perceptions of social status and social class. Socioeconomic status can encompass quality of life attributes as well as the opportunities and privileges afforded to people within society. Poverty, specifically, is not a single factor, but rather is characterized by multiple physical and psychosocial stressors. Further, SES is a consistent and reliable predictor of a vast array of outcomes across the life span, including physical and psychological health. Thus, SES is relevant to all realms of behavioral and social science, including research, practice, education, and advocacy.

SES AFFECTS OUR SOCIETY

SES affects overall human functioning, including our physical and mental health. Low SES and its correlates, such as lower educational achievement, poverty, and poor health, ultimately affect our society. Inequities in health distribution, resource distribution, and quality of life are increasing in the United States and globally. Society benefits from an increased focus on the foundations of socioeconomic inequities and efforts to reduce the deep gaps in socioeconomic status in the United States and abroad.

SES AND END-OF-LIFE ISSUES

Research has highlighted several areas where SES appears to significantly affect end-of-life issues. Some areas include early detection of terminal illnesses, racial and economic disparities, and the quality of life for people diagnosed with terminal illnesses. This fact sheet aims to expand on these areas, noting the ways that SES acts as a moderator.

Disparities in Chronic and Terminal Illnesses

Recent research has found disparities in early detection of terminal illnesses among persons of varying SES. Lower SES has been associated with less utilization of preventative and early detection services—methods that may prevent or mitigate the effects of potentially terminal illnesses.

- On average, African Americans lived 8 years less than Hispanic men and 6 years less than White men (Kochanek, Xu, Murphy, Miniño, & Kung, 2011).
- Although African Americans may be more likely to seek out some screenings compared to White men, significant health disparities still exist (Thorpe, Bowie, Wilson-Fredrick, Coa, & LaVeist, 2013). One study found that health disparities cost the U.S. tens of billions of dollars per year. These costs seem to be disproportionately connected to older low-income African Americans in urban areas (LaVeist, Gaskin, & Richard, 2009).
- Between 2011 and 2012, only 58.8% of eligible low-income women, ages 40 to 60, participated in free mammography screenings provided by the National Breast Cancer and Cervical Cancer Prevention Program (Howard et al., 2015).
- African American women with only female sexual partners in the past year were significantly less likely than White women to have had a Pap in the last year (Agénor, Krieger, Austin, Haneuse, & Gottlieb, 2014).

The difference in utilization of early detection screenings may be influenced by the likelihood that persons of lower SES more often hold jobs that offer partial or no health insurance coverage. However, some research indicates that disparities in utilization exist even when these services are covered by a health plan, suggesting the need to educate persons of low SES about the benefits of early screenings and preventative care.



These screenings increase the chances of diagnosing a disease early. A later (and often less treatable) diagnosis is likely when individuals do not participate in these screenings. Later stage diagnosis appears to affect persons of lower SES more than would be expected by chance:

- Minorities and those with lower SES are at increased risk of being diagnosed with late-stage cancers compared to Whites and those with higher SES (Sun et al., 2011).
- African American women are less likely to receive timely and adequate cervical cancer treatment and more likely to be diagnosed with advanced-stage cervical cancer (Simard, Fedewa, Ma, Siegel, & Jemal, 2012).
- Compared to Whites, African Americans are 40% more likely to receive a late-stage cancer diagnosis, 50% less likely to have surgery for colon cancer, and 67% less likely to receive surgery for rectal cancer; however, African Americans have a slightly increased risk of death from colon cancer and a greater risk of death from rectal cancer (Hines & Markossian, 2012).

QUALITY OF LIFE

As the end of life approaches, many individuals participate in advance care planning (American Psychological Association, 2000). End-of-life choices can directly affect an individual's quality of life. Participation in palliative care programs has been shown to significantly improve quality of life in persons diagnosed with a terminal illness (Hui et al., 2014). Use of these programs, however, is not universal, and lower SES appears to be associated with less utilization of these quality-of-life sustaining programs. Additionally, patients with low SES receive more aggressive end-of-life care. They are also more likely to be treated with chemotherapy, have more frequent emergency room visits and be admitted into intensive care units, and die in the hospital (Chang et al., 2014). With this more aggressive end-of-life care often comes considerable cost, which can have long term negative effects on lower SES and economically marginalized families.

- Patients with lower SES are disadvantaged due to doctors' misperceptions of their desire and need for information and their inability to participate in the treatment process. For example, terminally ill cancer patients receive significantly less positive socioemotional support, are less involved in treatment decisions, receive less treatment information, and have less control over communication (Chang et al., 2014).
- Low-income identified people of color may have a higher likelihood to want family to take care of those at the end of their life and have a greater desire to engage in family decision making/consensus when making end of life decisions (Born, Greiner, Sylvia, Butler, & Ahluwalia, 2004).
- Low-income identified people of color may be less likely to use hospice due to lack of awareness of the service or fear of its cost, and may have less trust in the systems that provide end-of-life care (Born et al., 2004).

- The final year of life tends to be the most expensive both for the individual and for the U.S. government. Last-year-of-life expenses constituted 22% of medical expenses, 26% of Medicare, 18% of non-Medicare expenditures, and 25% of Medicaid expenditures (Hoover, Crystal, Kumar, Sambamoorthi, & Cantor, 2002).
- Religiosity and spirituality play a role in an individual's willingness to engage in advance care planning. Those who strongly believe that God controls the circumstances of their death are less likely to make end-of-life plans (Garrido, Idler, Leventhal, & Carr, 2013).
- There are potential differences between rural and urban dwellers in the use and availability of palliative care. Rural dwellers are less likely to use hospice and on average spend fewer days in intensive care units (Watanabe-Galloway et al., 2014).
- Children in end-of-life care have a high risk of financial stress. One study found that 62% of families who received palliative care services resided in high-poverty neighborhoods (Beaune et al., 2013).

GET INVOLVED

- Consider SES in your education, practice, and research efforts.
- Stay up to date on legislation and policies that explore and work to eliminate socioeconomic disparities. Visit the Office on Government Relations for more details: <http://www.apa.org/about/gr/pi/>
- Visit APA's Office on Socioeconomic Status (OSES) website: www.apa.org/pi/ses
- Visit APA's End of Life Issues and Care website: <http://www.apa.org/pi/aging/programs/eol/index.aspx>

Reference can be found at <http://www.apa.org/pi/ses/resources/publications/fact-sheet-references.aspx>.