

JAMA Forum: Social Status and Health: A Coming Issue for Physicians

BY [DAVID CUTLER, PHD](#) on [APRIL 17, 2013](#)

“The rich are different from you and me. They have more money,” a cynic once noted. The modern-day version would add a deeply troubling observation: and they live longer too.

The gap in life expectancy between the better off and the less well off is large. [In 2006](#), a 25-year-old with a bachelor’s degree could expect to live about 9 years longer than a similar person who did not graduate high school (see figure below). To put this in perspective, on average, a lifetime of smoking reduces one’s life expectancy by only 7 years.

Furthermore, the gap is growing. In the past decade, life expectancy has increased among better-educated people but stayed flat (for men) [or decreased](#) (for women) among less-educated people. Along with longevity differences come morbidity differences. [The health profile of groups with a lower socioeconomic status](#) (SES) at age 60 years is approximately equal to the health profile of higher SES groups at age 80 years.



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Policy Implications

The growing gap in health by social status has enormous implications for policy. A common suggestion to address fiscal problems in the United States

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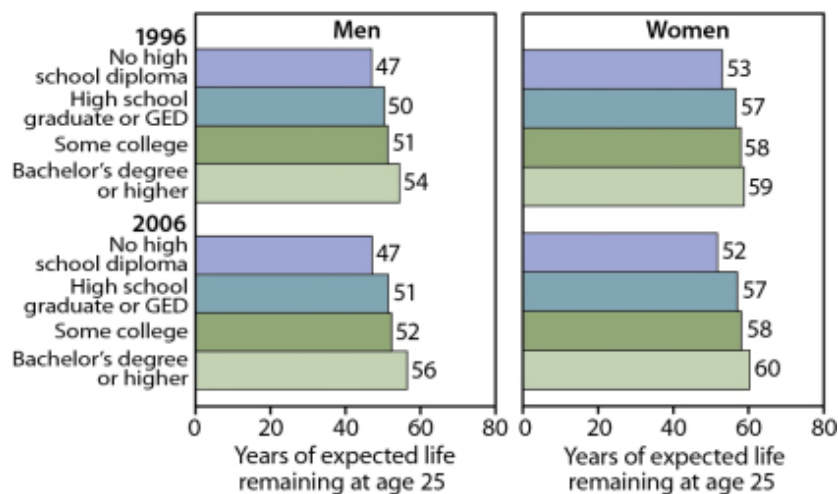
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is to increase the age of eligibility for Medicare and Social Security. For example, the [National Commission on Fiscal Responsibility and Reform](#) (aka Simpson-Bowles) and the [Bipartisan Policy Commission](#) (aka Rivlin-Domenici) both recommended indexing the Social Security eligibility age to longevity. Because people are living longer, why shouldn't more of those years be spent at work?

But the unequal gains in life expectancy make this decision complex. Engineers, economists, lawyers, and doctors are living longer lives. Does that mean that hospital orderlies and medical reception staff should receive fewer years of Medicare and Social Security? Since their health at age 65 is worse, can they even work longer? It is hard to have one social insurance system when we effectively have a country with 2 unequal groups.

Life expectancy at age 25



NOTE: GED is General Educational Development high school equivalency diploma.
SOURCE: CDC/NCHS, Health, United States, 2011, Figure 32. Data from the National Health Interview Survey Linked Mortality File.

Implications for Medical Practice

As physicians move into accountable care organizations (ACOs), these health differences by social status will become increasingly important. In an ACO, physicians get paid to manage population health. A contract arrangement that rewards physicians based on outcomes for the group, such as for low rates of heart attacks, provides strong incentives to understand why lower SES groups have heart attacks at much younger ages and to intervene to prevent this.

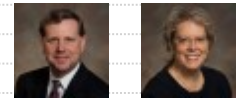
What then do we know about addressing these social gaps in health? The answers are not totally clear, but there are some insights from the literature. One common idea is that these differences are intrinsic and cannot be varied easily. The difference between those who are rich and those who are poor has been attributed to the willingness of people to invest in their health—to stop smoking, to eat a healthy diet, and to take medications appropriately. However, this theory is not right. [Even people who are compelled to stay in school](#) because of laws requiring reaching a minimum age before dropping out live longer than people who are allowed to drop out earlier.

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Being in school appears to have some fundamental effect that promotes longevity.

Two other factors seem to be at work. The first is the correlation between education and the ability to think through complex situations. [Ask a random sample of people in the United States the question](#), “True or false: If I were in an accident, I would want to have my seat belt on.” About 90% to 95% of them agree with this, independent of education. But the question “Seat belts are just as likely to harm you as help you” elicits a different response. More than half of people without a high school degree agree with this statement, compared with fewer than 20% of better-educated people. In general, better-educated individuals seem to understand the complexities of risk information better than those who are less educated. Similarly, a very high percentage of people with uncontrolled cardiac risk factors report in surveys that they did not understand the advice their physicians gave them about diet and medication. This difficulty in comprehending medical advice is particularly true for less-educated patients.

Thus, effective outreach to close this comprehension gap must be part of the package. The bad news is that many physicians are poor at outreach. They speak to patients using language that requires sophisticated understanding when the nature of the message needs to vary across individuals. The good news is that physicians are not the most important part of outreach. Well-trained health coaches have been shown [to increase use of chronic care services](#) and reduce use of acute care. The primary qualification of good health coaches is not that they know medicine, but instead that they are good working with people. The physician of the future may have to hire with this in mind.

Addressing Stressors

More difficult to address is the cascade of stressors affecting lower socioeconomic groups. Stress comes from all phases of life: jobs, the external environment, financial difficulties, and social conflict. [Research has shown](#) a clear link between the cumulative stress that a person is under and subsequent development of a variety of risk factors, resulting in earlier onset of severe disease. It is as if the aging process itself is more rapid in lower SES groups.

Certainly, physicians should be aware of this and screen for it. Recognizing the differential extent of disease at different ages is important in managing population health. But there is relatively little that physicians can do about preventing this cascade of stressors. There is not a single event that physicians can watch for or a simple test that captures the cumulative stress a person feels.

Ironically, the most effective intervention for a lifetime of stress may come from public sector institutions. Delaying the eligibility age for Social Security and Medicare, reducing funding for Medicaid, and cutting back on other

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social services would likely add to the stress that lower socioeconomic groups face, perhaps increasing the risk of early disease. In the future, this could hurt the financial performance of physicians who deal with patients from low socioeconomic groups. In short, physicians could have a vested interest in making sure the public sector alleviates the stressors of modern life. Physician incomes, as well as patient health, may depend on what we do with regard to social programs.

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