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Social Barriers and Cyclical Health Inequity: Addressing Disparities in Health

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Abstract

This mixed methods study examined the lived experiences of participants negatively impacted by the social determinants of health (i.e., physical environment, economic stability, education), and the repercussions regarding their ability to access quality healthcare. Three themes emerged: evidence of social determinants, barriers to healthcare, and the influence of health insurance. These three themes illustrate the interrelated nature of the social determinants of health and the cyclical entrapment of social injustice and health inequity. To address the realities of the impacts of inequitable healthcare on vulnerable populations, interventions must be initiated to enact tangible, positive change for vulnerable populations.

Introduction

Health inequities arising from the social determinants of health (SDOH) are systemically built into organizations and are further perpetuated with time. The influence that one's surrounding environment has on their health is multifaceted and reflects both current and historical social institutions, as well as the wider set of social systems that shape "the conditions of daily life" (Centers for Disease Control and Prevention [CDC], 2022a, para. 1). Those who are economically disadvantaged and less privileged live in worse health and die at a significantly younger age than those with wealth and more privilege (Phelan & Link, 2013). The social determinants of health can be thought of as upstream risk factors that impact health, and these factors are more prevalent in groups of lower socioeconomic statuses (Phelan & Link, 2013). As a result, these vulnerable populations are disproportionately impacted by poorer health outcomes and are at greater risk for developing chronic diseases, poorer mental health outcomes, substance abuse issues, and other avoidable health conditions (American Academy of Family Physicians [AAFP], n.d.; Bitely, 2021). These social determinants increase the risk factors affecting health outcomes and exist further upstream to the clinical setting due to inequitable access to goods, resources, and opportunities between social groups, and also cause health disparities, which are preventable differences in health status experienced in disadvantaged groups (Ansell, 2017). Recognizing the implications that socioeconomic injustices have is imperative to reducing disparities in health status and achieving greater equity in matters of health, life, and death.

Systemic inequity is a pervasive cycle. The longer that reinforcing patterns remain, the further ingrained they become and the more difficult they will be to dismantle. Fewer studies highlight the realities of those living at the intersection of inequality and health despite substantial research mapping the broad patterns that result in health disparity and outcome inequalities, particularly in the United States (Bolam et al., 2004; Gkiouleka et al., 2018). Existing research provides minimal insight into the actual lived repercussions that arise from the social barriers vulnerable populations face. This exploratory study addresses the current research gap, focusing on the lived experiences of those who endure the consequences of social inequality and on the challenges they face in obtaining equitable healthcare.

Background

Since the 1990s, health researchers have started to focus on the social and physical factors that not only increase the risk of infectious and chronic diseases, but also increase predisposing health risk factors (Catlin et al., 2010). These factors, termed the social determinants of health, are upstream conditions that arise depending on where a person is born, grows, and works, and they are shaped by powerful social, political, and economic forces (AAFP, 2018; Islam, 2019). The SDOH encompass a wide variety of societal influences, including access to healthy foods and quality healthcare, housing and economic stability, and reliable transportation (National Institute of Dental and Craniofacial Research, n.d.). However, the impacts that the SDOH have on health outcomes are not evenly distributed across all populations as a consequence of "structural racism, discrimination, and certain policies that can result in inequities observed in these determinants" (National Institute of Dental and Craniofacial Research, n.d., para. 4). Preventable differences in health status experienced in disadvantaged groups can be mitigated by addressing the SDOH (CDC, 2022).

The dominant social determinants include physical environment, economic stability, education, social composition, and the healthcare system (Artiga, 2020). It is important to acknowledge that this concise list of broad terms is only one way to categorize the much longer list of determinants that have lasting implications on one's health and that the social determinants have a unique interplay with health outcomes.

Physical environment plays a crucial role in determining the distribution of health outcomes and is directly related to numerous other determinants of health. Around 80% of the factors that affect health status are determined by where a person is born, grows, works, and lives (AFP, 2018). The conditions of the physical environment are deeply intertwined with economic stability and include housing conditions, population density, transportation services, recreational areas and greenery, sustainable food access, exposure to noxious agents, and proximity to infrastructure. Living in a disadvantaged neighborhood is associated with poorer health and fewer economic opportu-

nities when compared to less distressed areas (Sanbonmatsu et al., 2012). The interrelated socioenvironmental factors related to physical environment show that health risks will increase as neighborhood conditions worsen, as poorer neighborhood conditions are directly related to socioeconomic status (SES) (Anderson et al., 1997). Several studies have evaluated socioeconomic status and health through examination of employment opportunities, income, and expenses and have found that SES has an inverse relationship to health outcomes as a whole (Blane, 1995). In concurrence with both physical environment and economic stability, SES plays a role in education, with areas of lower SES coinciding with lower educational attainment (Ferguson et al., 2007). Health disparities emerging as a result of varying educational attainment also have implications regarding a decreased likelihood of seeking out or understanding "basic health information and services needed to make appropriate health decisions" (CDC, 2022b, para. 5). As a result, low SES, low educational attainment, and poor living and working conditions are all associated with overall worse health, shorter life expectancy, and an increased mortality rate (Raghupathi & Raghupathi, 2020).

The social composition of a community, including social integration and support systems, discrimination and racism, and stress, also affects health outcomes. Not only can a strong social network reduce the response to stress, but social inclusion can lead to greater levels of social cohesion and better standards for health (Wilkinson & Marmot, 2003). On the other hand, social exclusion resulting from racism, discrimination, hostility, and stigmatization typically prevents less privileged populations from seeking resources that enhance their health and well-being. These populations are particularly vulnerable and more likely to suffer from a range of health issues. Their health is also compromised by living in densely populated areas with high rates of unemployment, poor quality housing, substandard infrastructure, and limited access to resources (Wilkinson & Marmot, 2003). As with many of these determinants, social exclusion is often connected to economic instability, and this intersection has other indirect effects on health.

Lastly, the healthcare system including health coverage, cultural competency, provider availability, and quality of care has lasting implications on health outcomes. Ensuring access to quality healthcare and removing barriers that arise from the SDOH will require collaboration across a variety of stakeholders to transform the care available to underprivileged areas and to enhance and sustain health equity (Bhatt & Bathija, 2018). Evidence suggests that primary care medicine is associated with a more equitable distribution of health in populations, indicating that primary care consistently improves overall health and reduces health disparities in vulnerable populations (Starfield et al., 2005). No SDOH exists in isolation, as all of the determinants interweave with and exacerbate other determinants in a cyclical mechanism. This research will apply findings from the literature to better understand both the lived experiences of those encountering social inequality and how they make sense of the health disparities they face as a result.

Methodology

This exploratory study employed qualitative and quantitative methods to analyze lived experiences and subjective perceptions of a marginalized community to illuminate how existing social determinants result in cyclical health inequity. Based on the relevant literature and the data collected in this study, the quantitative evidence highlights how each qualitative theme fits into the larger discussion of the widespread implications of the SDOH. The study used semi-structured interviews with ten individuals who are less privileged and lower on the socioeconomic spectrum. Unintentionally, this research population resulted in part from snowball sampling, a method in which potential participants learn about the study from people who have participated previously. After recieving IRB approval with participant consent, all interviews were recorded and transcribed for purposes of coding and analysis. All of the respondents were given pseudonyms and any nonessential identifying information was removed to protect participants' confidentiality.

Participant Demographics

Several demographic criteria were collected, including age, gender identity, racial identity, and educational attainment. The ten participants ranged from 24 years old to 74 years old. Six male-identifying and four female-identifying participants were interviewed, with four participants identifying as White, three participants identifying as Black, two participants identifying as multiracial, and one participant

identifying as Hispanic. Educational attainment for the interview subjects varied from some high school education or a GED to a master's degree. Six of the ten participants were unhoused at the time of the interview, with the other four participants living in either temporary or permanent housing. Eight of the ten participants currently had health insurance; however, six of these eight participants were previously uninsured. The two participants who reported being currently uninsured were perviously insured at some point.

Qualitative Procedures

Semi-structured interviews, in combination with a survey questionnaire, were used to collect data. The semi-structured interview process began with each participant completing a survey to evaluate their demographic criteria, as well as how they perceived their health being impacted by the SDOH. Following the completion of the survey, inductive interviews were conducted, containing guiding questions predicated on the interviewees' lived experiences within the healthcare system. During each interview, additional questions based on the participants' answers to this study's SDOH survey were asked. The interview questions were based on the SDOH to learn about their personal experiences, and the survey was also referred to in the interviews to clarify information regarding their answer selection. Multiple aspects of each broad determinant category were evaluated to establish an association with the implications of the SDOH, as well as questions regarding the quality and accessibility of healthcare services.

Once the interviews were conducted, they were transcribed using a transcription software, Temi, and then coded using a digital coding program, NVivo, to inductively evaluate the data. During the open coding process, 24 codes were created to organize the initial commonalities among the ten interviews. To further narrow down the data, focused coding was used to narrow down the information to overarching themes, supported by more distinct concepts.

During both the interview and coding processes, it became clear that there was not necessarily a cause-and-effect relationship between social barriers and the quality and accessibility of healthcare services, but rather a cyclical relationship of social barriers reproducing common themes within the realm of health inequity. The final codebook included 12 concepts measuring three interrelated themes: evidence of social determinants, barriers to healthcare, and the influence of health insurance. Five concepts were used to provide evidence of social determinants, four concepts were used to determine the prevalence of being barred from healthcare resources, and three concepts were used to evaluate the influence of health insurance.

Quantitative Procedures

Two Likert scales were used to organize the comprehensive survey data from the ten participants. The first Likert scale was used to evaluate the level of healthcare satisfaction and the second Likert scale was used to evaluate the participants' self-assessment of the impacts of the six SDOH (economic stability, neighborhood and physical environment, education, food, community, safety and social context, and the healthcare system) on their health. The first quantitative methodology analyzed the participants' subjective assessment of their overall satisfaction with the healthcare system based on elements of access, quality, and overall health status. In addition to asking about overall health, respondents were surveyed about how they believed their health was impacted by a variety of social factors.

Results and Discussion

This research used a mixed-methods approach to examine the influence of social barriers and their contribution to the cyclical nature of health inequity. More than half of the selected responses revealed that the overall satisfaction of the sample group was moderate, with close to 30% reporting they were unsatisfied with the healthcare system, reporting poor access to healthcare, poor quality of health care, poor overall health, or a combination of the three factors (Table 1).

Respondents reported that the most prominent and frequent determinant impacting their health was economic instability, and in contrast they reported that educational attainment rarely impacted their health (Table 2). However, the qualitative themes provide a deeper understanding of the detrimental aspects of the SDOH, what they mean in the context of individual lives, and how they contribute to the cycle of social inequality and poorer health outcomes.

Table 1. *Level of Healthcare Satisfaction Scale and Frequency Distribution*

	Poor	Moderate	Excellent
Overall Access	4	5	1
Overall Quality	2	7	1
Overall Health	2	5	3
Total	8	17	5
Percentage	27%	56%	17%

Table 2. *Self-Assessment of the Impacts of the Social Determinants on Health*

	Health Is Rarely Impacted	Health Is Moderately Impacted	Health Is Frequently Impacted
Economic Instability	2	3	5
Neighborhood and Physical Environment	3	3	4
Education	8	1	1
Food	3	4	3
Community, Safety, and Social Context	4	4	2
Healthcare System	5	3	2

Evidence of Social Determinants

The most influential determinants perpetuating health inequity have arisen from structural social barriers. The concepts associated with structural social barriers that emerged during the interview process included economic instability, food insecurity, lack of transportation, socioeconomic triaging, and the assistance gap (the distance between the threshold for qualifying for public support and an actual living wage).

The realities of economic instability within this population show that it has been a constant struggle to manage their broader financial constraints with the demands of paying for basic necessities. Almost all of the research participants stated that the overwhelming majority of their income goes directly to pay for housing, electricity, food, and other living costs. Kennedy, a 32-year-old mother of four living in low-income housing and just barely making ends meet, described the measures she must resort to:

> The majority of my income goes to pay the bills and make sure my kids are taken care of. I've worked 16–18 hour shifts for six or seven days a week for more than two weeks straight just to make a living and have the basic necessities. It's draining to never have anything left over and I'm constantly struggling.

Dealing with similar economic fragility, Portia, a 64-year-old waitress providing for her three grandchildren, broke into tears as she expressed,

> My income goes straight to paying for cable, electricity, water, food, and clothes for the kids. Just the basics. It's something I'm constantly thinking about; I go to sleep thinking about what bill I have to work on paying the next day, constantly nagging in the back of my head. I work more than 32 hours a week as a waitress. I can't stop working, ever.

The daily realities of working a low-wage occupation can be detrimental to individuals and to families, compounding the impoverished living conditions that low-wage workers already experience. The types of economic instability the respondents reported are associated with increased stress, a greater tendency to engage in unhealthy behaviors, and negative health outcomes that "further hinder employment and income growth" (Yarrow, 2015, para. 7).

Food insecurity was another prominent concept pointing towards and exacerbating social determinants. In 2020, it was projected that one out of every six adults and one out of every four children in the United States faced food insecurity at some point (Housman, 2020). In the current study, the partici-

pants receiving SNAP (Supplemental Nutrition Assistance Program) benefits as a result of their financial constraints felt as if access to food was a life-or-death situation. Walter, a 46-year-old man self-described as "chronically homeless," believed that SNAP benefits saved his life multiple times. Similarly, Brianna, who remembered barely affording anything other than a slice of bread for her child's school lunch, revealed that she dealt with so much uncertainty and stress as a result of being food insecure that she often asked herself how much longer she would have left to live if she lost her SNAP support.

Respondents also highlighted that access to easy and affordable transportation was a significant struggle numerous times. In an economically unstable population, the only accessible transportation is public transit, which for these participants was the bus system. The interview participants explained the significant impacts resulting from a lack of access to affordable or reliable means of transportation. Tucker, a 26-year-old unhoused man, spoke about needing to allocate an extra hour or two to ensure that he arrived at his destination on time. He described the overwhelming feelings of stress as "constant mental nagging." He stated,

> I have to wake up an hour earlier so that I can walk half an hour to the bus stop, and then another half hour from the bus stop that gets me closest to work.

The stress and demands of time tied to transportation can make handling even basic tasks or errands more difficult to manage, with cascading consequences across other dimensions of the respondents' lives.

The social roadblocks illustrated are interwoven with another common pattern throughout the interview process: socioeconomic triaging. Participants described having to continuously pick which resources they would be able to afford at a given time; forced to decide which of their basic needs were most urgent. Both Kennedy and Portia described the stress of either paying a bill related to basic living expenses or buying groceries that month. Each of them stated that making this choice repeatedly is "utterly draining" and that living in this situation "is a constant struggle of being exhausted," respectively.

The last prevalent concept across the interviews was the assistance gap. Kennedy explained that she continues to deal with the repercussions of social inequality but falls into the assistance gap:

> I work two jobs and because I make enough money to stay afloat, it's considered that I make too much to qualify for any type of assistance. You pretty much got to be dead to get help.

Despite Kennedy's constant struggle, she still does not meet the minimum requirements for assistance. As a result of this population constantly dealing with substantial social barriers, their ability to access quality healthcare services is impacted. Brianna embodied this concept, describing how she must choose which medication she can afford to take before she gets paid each month. Despite her current socioeconomic circumstances and her monthly struggle to make ends meet, she also falls into the assistance gap. Several other participants described a similar healthcare roadblock. For example, Portia also has to prioritize either her health or her basic living expenses. She stated,

> I have to sacrifice going to the doctor or taking my prescription medications so that I can pay for rent. It's a constant cycle of picking and choosing and stressing about how to manage each and every day. But we make it.

Social determinants of health have a much wider impact on a multitude of other institutions, and these social factors influence and exacerbate additional barriers faced within the healthcare system.

Barriers to Healthcare

The numerous social barriers that exist have direct implications on how marginalized populations obtain healthcare services. The roadblocks that emerge as a result of social determinants of health tend to accumulate and result in negative health outcomes among disadvantaged populations (Wilkinson & Marmot, 2003). From the interviews, leading barriers included affordability of services, accessibility of services, quality of services, and stigma from healthcare providers. Eight of the ten participants felt as if their health had at some point been impacted as a result

of being financially insecure, and the role of unpaid and unaffordable medical bills played a part in that response for quite a few of the respondents.

After getting into a life-threatening car accident years ago, not only did Kennedy lose her reliable form of transportation, she also racked up a medical bill reaching well over $80,000 due to being uninsured at the time. Similarly, Brianna underwent a knee replacement nearly two years ago, leaving her with an unaffordable medical bill. A majority of this population described needing to see a medical practitioner without being able to afford the visit. With costly unpaid medical bills hanging over their heads, accumulating more of them is simply not an option. As a result, the participants in this study often opted out of preventative and maintenance health care in addition to care for other basic health concerns. When deciding to either pay for prescription medications, a doctor's visit, or a roof overhead, the choice was usually self-explanatory for these participants. Benjamin, a 30-year-old man without health coverage, provided an example of dealing with this conflict:

> You have to have the money and the availability and the flexibility within your finances to say, 'Hey, I can afford to get this treatment.' It's expensive to take care of yourself other than sticking to basic necessities of food, transportation, and living expenses. And sometimes I can't even do that.

Despite the monstrous roadblock of unaffordable healthcare, it was only one component of many barring these participants from having access to healthcare resources.

When each participant was asked what their primary barrier to accessible healthcare was, there were three notable responses: lack of transportation to appointments, cost of services, and receiving only the bare minimum of treatment. When relying on public transportation, patients are forced to depend on an often unreliable system. Walter said,

> There have been many times I've missed appointments because I couldn't get there. Whether it be taking the bus system or having to allocate two or three hours in addition to just getting there. If I didn't show up to an appointment, it was because I didn't have the transportation to get there.

Walter also provided insight into the other two responses regarding both the cost of services and receiving the bare minimum treatment. The extreme price of healthcare was a concern, even for those insured through Medicaid and especially for those participants who are currently uninsured. These individuals struggle to afford basic living necessities, and the massive out-of-pocket costs associated with healthcare services are often too large of a financial burden to bear. Further, a handful of both underinsured or uninsured research participants felt that when they sought out healthcare, they would receive the bare minimum of care.

Both barriers to the quality of healthcare and stigma from healthcare professionals contribute to the study participants' feeling that they have been provided with the bare minimum. A common trend related to receiving the bare minimum treatment concerning the quality of healthcare was due to patients not spending enough time with their physicians. Portia stated,

> There's definitely been a few occasions where I've felt rushed through the appointment, that my concerns weren't important to the doctor.

Brianna shared the same dissatisfaction, mentioning that her insurance dictates the length of time her physician is allotted to spend with her per visit. This has resulted in the physician spending an inadequate amount of time with her during the visit and contributed to the feeling of receiving the bare minimum of care. Patients reported experiencing stigma from healthcare practitioners, which further exacerbates feelings of receiving the bare minimum of care. Josef, a 34-year-old unhoused man who very infrequently sought out healthcare services stated,

> I feel like there was a social stigma attached to uninsured and homeless people in the hospital. They just do the bare minimum and send you on your way with no follow-up planned.

Josef and other interview participants felt the quality of care provided to them by physicians or other healthcare staff was of lower quality as a result of the perceived stigma tied to being unhoused, uninsured, or both. This resulted in patients feeling that they received bare minimum and substandard treatment. In his experiences, Walter further observed,

> I think because I'm homeless, the quality of healthcare that providers give me is horrible. They judge you in a different way and have less respect because you don't represent a high ticket. You represent low-budget, Medicare work, and that's it. It's not a profit for them. So they're not going to treat you as if you're going to give them any kind of money. They ignored me and treated me as if I didn't exist. It's sad that in the system in which doctors vow to do no harm, they do in fact do harm. Sometimes more than good.

Regardless of whether providers harbored ill sentiment toward unhoused and underinsured or uninsured patients, the accounts of patients like Walter highlight the real human costs in the patient experience at the intersection of inequality and healthcare.

The social determinants of health embedded in society are central to the larger context of health disparities. Not only are the effects of health disparities pernicious, they are further exacerbated by a multitude of external factors, one of which is inadequate health coverage.

Influence of Health Insurance

Given the extreme cost of healthcare, the presence or absence of health insurance had tremendous impacts on the lives of the participants. Those who were unhoused but insured described having remarkably better health outcomes in terms of both access to and quality of care compared to those who were housed but uninsured. Health coverage provided these participants with a sense of security, a feeling that they struggled to find elsewhere due to the uncertainty that they faced daily. Taylor, an unhoused middle-aged woman and a self-identified recovering addict, stated,

> If I ever lost my Medicaid, how would I pay for my treatments? I would die. Medicaid is basically allowing me to live. It's absolutely life-changing, pivotal in helping me to get back on my feet.

For Taylor, having health insurance meant survival. Throughout the interview, she repeatedly expressed her gratitude for a second chance at life and attributed a majority of that chance to qualifying for Medicaid. While Taylor was provided with the life-changing effects of health coverage, others are not as fortunate. Just over 6% of Virginia's total population and 8% of Virginians under the age of 65 remain uninsured, and being without coverage is associated with decreased use of medical services and increased rates of mortality (Kaiser Family Foundation, 2022; Tolbert & Drake, 2022; Virginia Health Care Foundation, 2022). Qualifying for health coverage provides individuals like Taylor with access to life-saving medical resources.

The overwhelming consensus given by the participants was that health insurance meant that they never had to purposefully avoid going to the doctor due to other financial obligations. Garrett, a 46-year-old unhoused man, stated,

> I now have access to the help I need to get healthy and I don't need to intentionally avoid seeing a doctor if I need to go.

Having health coverage provided these participants with the entry point necessary to maintain their health by making these resources more affordable, alleviating the struggles and stress associated with not having accessible healthcare.

In contrast, living without insurance is a roadblock to receiving the most basic healthcare resources. Many of the research participants explicitly stated that they would intentionally avoid going to the doctor because they could not afford a medical bill of any magnitude. For those who had no choice but to seek out medical services, they were forced to spend years, if not decades paying off the bills. Three participants voiced similar stories: Brianna spent more than 5 years paying hospital bills from when she was uninsured, Josef is still paying hospital bills more than a decade after his admittance, and Taylor, who was uninsured

when she underwent two open-heart surgeries, has no idea if she will ever finish paying her medical bills. Taylor said,

> I can't even imagine how much I owe. You can't get anything out of somebody who doesn't have it to begin with.

With these individuals already struggling to pay for basic living necessities, adding an extensive medical bill would introduce additional and seemingly unmanageable stress to their lives. The majority of the research participants experienced living both with and without insurance, with the largest difference between the two realities being the amount of stress experienced. Having health coverage dramatically decreased the cost associated with healthcare services and the financial stress associated with affording care was eliminated.

Cyclical Mechanisms Reinforcing Health Inequity

It is impossible to identify a social determinant of health that neither influences nor is influenced by other determinants. Poverty and health have been documented in the literature, with poverty being linked to poor nutrition, unstable housing, and limited educational and employment opportunities (Health Poverty Action, 2017). Those harsh realities result in impoverished populations dealing with diminished income, inadequate access to care, and poorer health outcomes, with the lack of quality healthcare reinforcing impoverished conditions (Institute for Youth in Policy, n.d.; Thompson et al., 2019). As the participants' interviews illustrated, the three themes marking their experiences of accessing healthcare exist within an interrelated, cyclical reality, operating in covert ways with lasting ramifications. Almost all ten of the participants explicitly mentioned feeling stuck within the cycle, constraining them within their social class. Kennedy explained how she has constantly struggled to pull herself and her family up the socioeconomic ladder:

> I don't have a car and because I have to rely on public transportation, I have to take time off of work and plan my day hours in advance. It is so time-consuming and I lose out on the money I could've made if I had my own vehicle. On top of that, it's a constant cycle of having a low-paying job barely making ends meet, but I'm making too much to qualify for assistive services.

These participants simply do not have adequate time, money, or resources to escape the cycle of poverty and establish a sustainable future. Benjamin explained his struggle trying to find a job:

> I'm job hunting, but when you don't have a car you have to find another way to get there to get to the interview, and you can't invest in a car until you get said job. But I don't have a car to get to said job or interviews, and it leaves me in this cycle, a vicious cycle.

This story was repeated in eight of the ten interviews, exemplifying the cycle of inequality. These realities highlight the structural barriers that contribute to ongoing economic precarity and limiting mobility from one social class to another, completely unrelated to individual effort or motivation.

The interconnected, cyclical relationship of the SDOH is ever-prominent in healthcare and health inequity. For example, Walter explained how one hospital stay impacted several determinants of health:

> I went to the hospital for one stay. My insurance carrier had just dropped me, and it took me over a decade to pay off those hospital bills. About 45% of my income went straight to the medical bills I racked up from one stay over 10 years. I lost my job due to being hospitalized, and I then couldn't pay for my car, which in turn prevented me from having reliable transportation to the food bank, so I struggled to eat. It affected everything. I had to restart my whole life. I'm still getting back on my feet more than 10 years later.

The cyclical nature of this lived inequality, evident in several other interviews, is due to the lack of resources or opportunities available to advance (World Vision, n.d.). The poverty traps that oppress this population have detrimental impacts on health and well-being. Jason, a 38-year-old unhoused army veteran,

exemplified this:

> I would like to have a primary care provider, but I don't have reliable transportation, so I would have to leave work early to make it to appointments on time. I can't leave early because I need it to work to survive, but the more I work the more my body is in pain. I have no choice besides working through the pain.

Portia, a woman who has lived in this cycle her whole life, described a similar story:

> I have several health concerns that surgery could fix, but there's no way that I could afford to take 5 or 6 months off to recover. So I have declined surgery due to my economic situation. The pain impacts me every day, I hurt all the time, but it's just something else I have to push through.

For impoverished communities, healthcare is both practically inaccessible and too often inadequate, and these populations lack the resources to advocate for themself and alter their circumstances (World Forgotten Children, n.d.). The intertwined factors affecting health both reflect and reproduce systemic social inequity. To improve health equity for disadvantaged populations, we must acknowledge the underlying root causes that lead to poorer health outcomes (Andermann, 2016).

Conclusion

The specific aim of this study was to better understand the lived experiences of those who deal with the implications of cyclical inequality and how it impacts their ability to access quality healthcare resources. Analyses of the semi-structured interviews revealed that social determinants of health had a negative, cyclical relationship with barriers to healthcare. Analysis of the qualitative data also revealed that the most common patterns exacerbating barriers to healthcare included inadequate access, quality, cost, and stigma, with the presence or absence of health insurance further influencing healthcare barriers.

Rather than simply describing the social barriers that exist, the design of this research was meant to provide insight into how this marginalized community navigates the barriers that exist and how these barriers may disproportionately impact those lower on the socioeconomic spectrum. As demonstrated by prior research and illustrated in this study, the social determinants of health have had immense detrimental implications on this population's ability to access services and resources needed for their health. The research exemplified the fundamental theory that describes how those who are economically disadvantaged and less privileged are subjected to additional risk factors impacting health while living in worse health than their economically advantaged and privileged counterparts (Phelan & Link, 2013). The repercussions of social inequality can be addressed by creating upstream interventions to tackle the fundamental causes of disease and illness at their source.

While the results of this study align with previous literature on the associations explored, it is important to acknowledge an important limitation of this study. The small sample size of this study may indicate a lack of generalizability to the greater population experiencing social barriers. To draw causal conclusions about the association between social barriers and disproportionate health outcomes, additional research with a larger sample population comparing those same associations in communities facing social barriers against communities with greater social advantages would be beneficial. Exploring these relationships in additional populations could uncover the extent to which health outcomes can be attributed to the social barriers examined in the present study. Research on this subject matter provides greater insight into the lived experiences of inequality on an individual level, allowing a more in-depth comprehension of a population's experience. Understanding the interrelated nature of the social determinants of health and their relationship to health outcomes is imperative when implementing strategies to address disparities in healthcare.

Author's Note

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Kaitlyn Gentille ('23) completed a double major in Sociology and Independent Scholars. Kaitlyn is currently working towards her Masters in Public Health at the University of Virginia (UVA), concentrating in Health Policy, Law, and Ethics. At UVA, she is involved with research in the Division of Prevention, Equity, and Population Health working as a Research Assistant at the Center for Tobacco Prevention and Control. Kaitlyn also serves as an Ambassador for the Truth Initiative, focusing on tobacco-attributable health disparities. She will continue advocating for positive change while addressing the root causes of health inequities as a public health practitioner upon her graduation in December 2024.

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