Social position and judgment of health care services by users[1]

Posição social e julgamento dos serviços de saúde pelos usuários

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Abstract

To investigate the relationship between the judgment of health care services by users and their position in the social space, we performed a study supported by the sociology of Bourdieu involving two groups. Twenty-two in-depth interviews were conducted with university professors and users of the health care system. The social position of these agents was characterized by analyzing their available capital and their social trajectory. We found that the choice of physicians by those users with greater global capital was linked to technical and symbolic criteria. In contrast, among agents of the popular classes, access was the main criterion. We analyzed that the stance taken regarding the service corresponds to an unconscious adjustment between needs and the possibilities available to users. We discussed the implications of a social distance between physicians and their patients in choosing and judging health care services.

Keywords: Health care services evaluation; *Habitus*; Physician-patient relationship; Patient satisfaction; Health care service use.

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Resumo

Com o objetivo de investigar as relações entre o julgamento dos serviços de saúde pelos usuários e a sua posição no espaço social, foi realizado um estudo apoiado na sociologia de Bourdieu envolvendo dois grupos. Foram realizadas 22 entrevistas em profundidade com professores universitários e usuários de unidades de saúde. A posição no espaço social desses agentes foi caracterizada por meio da análise dos seus capitais e trajetória social. Identificou-se que a escolha dos médicos entre os agentes de maior capital global vinculava-se a critérios técnicos e simbólicos. Em contrapartida, entre agentes de classes populares, o acesso foi o principal critério. Analisou-se que a tomada de posição em relação ao serviço corresponde a um ajuste inconsciente das necessidades às possibilidades dos usuários. Discutem-se as implicações da distância social existente entre médicos e pacientes na escolha e julgamento dos serviços de saúde.

Palavras-chave: Julgamento dos serviços de saúde; *Habitus*; Relação médico-paciente; Satisfação do usuário; Utilização dos serviços de saúde.

Introduction

High user satisfaction levels, unrelated to the quality of the health care service used, have been reported in the international literature over the past few decades (Batbaatar et al., 2015; Atkinson; Haran, 2005; Bernhart et al., 1999). The explanations for this paradox have been attributed to the lack of information and a tendency towards low expectations regarding the service itself (Atkinson; Medeiros, 2009; Williams, 1994; Williams; Coyle; Healy, 1998), as well as possible biases such as is the case of courtesy or gratitude (Glick, 2009).

The study on the reasons for a high user satisfaction found in these works, particularly in the southern hemisphere, is still recent and its findings are contradictory (Atkinson; Medeiros, 2009). Generally, two key groups of determinants have been investigated: variations according to the characteristics of users and factors linked to the provision of health care (Crow et al., 2002). Aspects of political and cultural contexts have also been linked to satisfaction (Atkinson; Haran, 2005).

The characteristics of the individual's position on social space such as income and education, have been placed second in relation to the dimension of the services (Baltussen et al., 2002). Thus, in most studies on satisfaction, there is no differentiation between service users, ignoring social space characteristics. There seems to be an implicit assumption, shared by the studies, that consider all users to be homogeneous from a social point of view, all are equally able and interested in evaluating the services, using the same criteria.

In studies that investigate the relationship between satisfaction and income, the results are contradictory. There are reports of direct association (Khayat; Salter, 1994), as well as of reverse association (Hall, Dornan, 1988). Those in which age is considered, the results are more consistent, and there is a direct relationship between this variable and satisfaction (Sitzia; Wood, 1998; Blanchard et al., 1990). When the different characteristics of users and services are used to evaluate patient satisfaction with hospital care, such as a study performed in the Netherlands (Hekkert et al., 2009), the first had a statistically significant influence on patient satisfaction, with age, health and

education as the factors that most influence user satisfaction. Sex, mother tongue, type of hospital and hospital size were less important variables (Hekkert et al., 2009).

In Brazil, most research has investigated public health services by assessing the satisfaction of users from popular classes (Vieira; Souza, 2011; Mendes, 2009; Kantorski, 2009). Few studies have evaluated the satisfaction of users with the private service (Gerschman et al., 2007; Cartaxo; Santos, 2007) and none compared the two groups.

Incorporating the social side has been made in a limited way, without the use of a sociological theory able to guide the formulation of hypotheses about the causes of the high satisfaction paradox. This study aims to contribute to the understanding of social processes linked to the judgment of health care services by the users and their meanings, supported by Pierre Bourdieu's theory on social practices.

Methodology

A comparative study on the judgment of health care services performed by agents from different social spaces, was carried out, supported by Bourdieu's reflexive sociology.

For the author, the taste for various cultural goods varies according to the position of the individual in fields or social spaces, which correspond to networks of relationships defined by the positions arising from several species of owned capital. The positions occupied influence the positions taken, led by a *habitus* corresponding to the unconscious dispositions that guide choice, taste and social practices among which we have the use of health care services.

The first group, characterized by a high global capital, was composed by 12 university professors from the Universidade Federal da Bahia, chosen by colleagues with a high scientific capital. The second group, composed of 10 members of a basic health unit located in a popular neighborhood of Salvador, Brazil, considered a low global capital holder, was selected from an initial appointment by community leaders. Subsequently, the snowball method was used for the selection of others chosen to be interviewed in both groups.

A total of 22 in-depth interviews were performed by the lead author of this study in the respondent's home or in their workplace, between January and September of 2008. The interview was composed by general questions about the social history of the respondent, about their work, their recent use of health care services and their perception of them, as well as information on their health insurance, when this was the case. We asked the participants to narrate a recent experience with the health service and their perception of this. Issues related to social status were measured by the occupation of the interviewees and their parents. The interviews were recorded with the permission of the respondents and later transcribed for analysis. The names of the users were not disclosed in this publication, as well as the names of the physicians, which have been replaced. The project had prior approval by the Ethics Research Committee (001-08/CEP-ISC of 02/26/08).

The position occupied by the respondents in the social space was objectified by measuring the total volume of capital and its composition, as discussed by Bourdieu (1975, 2004, 2005, 2006). The *cultural capital* corresponds to the set of symbolic assets accumulated by an agent and was analyzed using their education and degrees. As a proxy of that capital, university professors had their academics scientific capital analyzed, and for users, their educational capital. The *economic capital* was analyzed using the family income and occupation of the individual. The accumulation of various forms of capital was named global capital.

The *social origin* of the agent was studied using the occupation and the education of the respondent's father, classified as high, medium or low. The social trajectory corresponds to social mobility and was measured by the distance between the social position of the individual and their social origin. The trajectories were classified as stable (when there is no variation between the position and the social origin), upward (indicating progression in the social space occupation, with greater accumulation of capital and their types) or downward (indicating otherwise).

The *social capital, which is the result of capital belonging to a specific group*, was measured through networking, interpersonal relationships

and friendships of the agents. The positions taken were investigated using the choices of the agents regarding physician and health insurance.

For the classification of the scientific capital of the professors, we analyzed the Lattes Curriculum. For the *pure scientific capital* analysis, we considered the number of publications (articles, books and book chapters published in Brazilian and international journals), master's and PhD guidance counseling and the position in the search directory of the National Council for Scientific and Technological Development (CNPq). For the *institutional scientific capital*, we considered the links to universities, such as leadership, coordination, direction, pro-rectors; rectory; member of the administrative committee and member of the higher council. The *symbolic capital*, as a *recognition capital* was measured by scientific merit awards, member of the editorial board and journal reviewer, as well as the recognition of society (articles published in major newspapers, participation in television programs). Using the description of this capital, we estimated the *global scientific capital* that, in turn, was ranked:

> *High*: have a high, pure scientific capital (scientific productivity grant 1- 1A, 1B, 1C, 1D, according to the CNPq classification, a funding agency of Brazilian research), or have published at least 20 papers in scientific journals, have completed the guidance of at least 14 master's/PhD degrees, be the guidance counselor of at least 4 master's/PhD degrees, have a well-defined line of research (directory leader) or have articles published in major newspapers, have appeared in television programs, have scientific merit awards;
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> *Medium*: have a medium, pure scientific capital (productivity grant 2 or have published at least 5 scientific papers in journals, have completed the guidance of at least 1 master's degree, be the guidance counselor of at least 4 master's/PhD, have a well-defined line of research (directory leader), or have an university capital (institution director or coordinator);
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> *Low*: have a low, pure scientific capital (less than 5 national articles, be the guidance counselor only of undergraduate monographies) and have no university capital.

Results and Discussion

Class *habitus* and choosing a physician: taste of luxury and taste of necessity

The analysis showed that the choice of physician differs considerably according to the position of the agents in the social space, and also within the study subgroups (Tables 1 and 2). The higher the global capital of the professors, the greater the freedom when choosing a physician, made or by indication of a network of social relationships or personal contacts with other physicians. In contrast, faculty with lower scientific capital often choose at random, according to availability in the reference list, or in some more privileged situations, referred by the health insurance's social worker. Consultation with a social network of reference was mentioned less frequently among these professors. Since they have a low global capital, they adjust their choices according to the possibilities, choosing physicians from their health insurance or, ultimately, physicians who charge the same as the insurance value (Chart 1).

In general, the choice of physician among university professors with high scientific capital presupposes, firstly, a prior recognition of the physician's competence. This recognition may have been induced by another physician's recommending a colleague, by the reputation of the physician or by successful patients, who are often relatives and friends. The family network, which corresponds to a kind of social capital, was mobilized by almost all respondents with medium and high scientific capital, notably those who were female.

The indication by another trusted specialist was reported by male professors, with this criterion considered as "technical" and "rational", which selects according to the medical expertise, after all "good doctors, the few, know each other" (P4, university professor, 47 years old, high global capital and medium-high scientific capital) or "I ask my physician for information [...] they recommend each other, they choose each other" (P3, university professor, 64 years old, high global capital and high scientific capital).

Chart 1 – Criteria for choosing a physician according to the volume of global capital of university professors, Salvador, Brazil, 2008

Criteria for choosing a physician	Professors with low scientific capital and an upward trajectory from a popular origin	Professors with a medium or high scientific capital and an upward/stable trajectory from a medium/high origin
Only choose physicians listed by the health insurance	+++	
Choose using the catalogue	+++	
Ask for an indication from the health insurance's social workers	+++	+
Choose physicians using access criteria (location and waiting time)	++	+
Choose physicians from their relations network	++	++++
Choose physicians from the private sector, despite having health insurance	+	++++
Choose physicians by their reputation	+	++++
Choose physicians indicated by other physicians		++
Use the health insurance only for hospitalizations and medical exams		+

Adapted from Chaves and Vieira-da-Silva (2008)
+ Presence of this characteristic in up to 25% of the group agents
++ Presence of this characteristic in up to 50% of the group agents
+++ Presence of this characteristic in up to 75% of the group agents
++++ Presence of this characteristic in up to 100% of the group agents

The suggestion by the health insurance's social worker, reported by three professors, also indicates the election of a technical criterion, since she was considered as "someone who has worked for the insurance for many years" and knows the most sought and best physicians, although this criterion has been questioned by a professor with high scientific capital, "the most sought after are not always the best" (P1, university professor, 53 years old, high global capital and high scientific capital), which indicates a weaknesses in the relationship with the social worker. The use of the insurance's social worker can also reveal the lack of social capital, a network of relationships that may produce reliable information regarding physicians worth consulting.

We also observed the random choice of physician, in which there is not, initially, a relationship of trust, by professors with a low scientific capital, that choose from the reference list: "I pick up the book and take a chance: if we hit it off, I stay" (P11, university professor, 56 years old, low scientific capital) and secondarily by access criteria, such as location and short waiting time.

The use of a renowned, reputable physician is presented not only as a technical criteria, but may also represent status, distinguishing property between different social groups.

The capital was also an important element when choosing a physician. The decision-making process is largely influenced by the relationships network of individuals. Everyday exchanges between individuals represent the most influential and effective way of making choices and decisions.

The role of social relationships in choosing a medical service is central and was present in both surveyed groups. In the case of agents with a high global capital, it includes first their family and close friends, friends of the physician, as well as the physician himself, as an informant of new colleagues.

On the other hand, the choice of physician by the popular classes do not necessarily depend on the characteristics of the medical practice, but on the criteria related to access, such as easy location of the health care services (Chart 2).

Chart 2 – Criteria for choosing physicians by users of the popular classes according to volume of global and educational capital. Salvador, Brazil, 2008

Practices	Users with a low global capital and a low cultural capital	Users with a low global capital and medium and high cultural capital
Only choose and use physicians from the Brazilian Unified Health System (SUS)	++++	
Choose health services near home	++++	++
Choose physicians using their relationships network	+	+++
Choose physicians from popular clinics		+++
Have health insurance		+

Adapted from Chaves; Vieira-da-Silva (2008)
+ Presence of this characteristic in up to 25% of the group agents
++ Presence of this characteristic in up to 50% of the group agents
+++ Presence of this characteristic in up to 75% of the group agents
++++ Presence of this characteristic in up to 100% of the group agents

It is noticeable that the choices are adjusted to the conditions of which they are products. The taste of the popular classes or *taste of necessity* (as opposed to the *taste of luxury*) engenders a whole lifestyle set in its negative form, by adversity, a relationship of deprivation maintained with other lifestyles.

Among the agents with low global capital, the network of relationships has been reported with less force. In such cases, the social worker is seen as someone able to facilitate the transit of the unit, indicating professionals and, in some cases, making appointments. The relationships established between the popular classes of those interviewed and their bosses and leaders were identified as links that aid, by indicating medical names and services or by facilitating access to the physician, expanding, albeit to a small degree, the universe of possibilities for these agents.

These findings are consistent with the findings of Bourdieu (2006), regarding popular taste interpreted by the author as a result of the distance from the need of medical attention. In his book, *The Distinction*, the position in the social space was defined by the composition of capital and social trajectory of the agent, which affects the mode of capital acquisition. In analogy to Bourdieu's work (2006), we analyzed that the choice of physician and the stance in relation to health services differ considerably according to the social position of the patient and the distance of necessity.

Criteria for physician judgment and the possibility of criticism

The agents with higher global capital tend to formulate a higher number of critics to physicians, while agents with low global capital adopt a less critical attitude to medical practice and tend to praise more regularly. This observation makes us wonder about the power relationships involved in the physician-patient relationship and poses the question of who has legitimate reason to criticize the physician, their conduct and their actions.

The perception of physicians by university professors is marked by ambivalence: on one side, a skeptical attitude that considers physicians "carriers of death sentences" (P1 interview) and "owners of the truth" (P8 interview); and on the other side, an unconditional attitude of submission to the medical knowledge and practice.

At first, physicians are perceived as those who do not refuse to transmit information about the patient's condition on their diagnosis or prognosis. The medical language is not questioned, being understood by professors who are able to reproduce it when they describe their clinical experiences.

Among the most important criteria in this group, there is trust and technical capacity. One expects the physician to treat their patients in a special way. They ought to remember the name of the patients, take time during each consult, attend them in a customized way, these are the characteristics valued by the professors. Patients choose the physician they consider apt to treat them and, by accepting this professional, they ratify their impressions and judgment about the physician.

However, discourse analysis shows that there are, at all times, questions about the medical power, and even the "abuse" of this power, such as the omission of information due to the belief that the patient is not able to understand the situation, or even the use of medications without proper explanation regarding the therapy and the health problem, or even without patient consent:

> *So I'm horrified when a doctor is absolutist. He is the owner of the truth, he is the owner of all knowledge... So, it give me chills when doctors treat you as if they were the owners of the truth!* (P8, university professor, 46 years old, high global capital, low scientific capital).

Quite differently from agents with a high global capital, the criticism from the popular class agents are directed to the health care service and refer, mainly, to access. The service is seen as a "disavowal", a metaphor for deprivation, lack of access, iniquity. When there is access to physicians, the assessment is almost always positive. The agents with a low global capital have no negative reports for their physicians: "I have no complaints about the physician" (E10 interview). With an increase in cultural capital (and relative increase of the global capital), we note a greater number of criticisms to the physician.

Adjustment degree to the choices and the strategies of distinction

The discourse analysis of the respondents, pointed to a different degree of adjustment between the agents regarding the choices and the practices related to health care services, i.e., the transformation of needs imposed by social position into apparently elective choices. These issues are made quite evident when analyzing the reasons behind to the choice of health insurances among university professors.

Among the group of professors with higher scientific capital, the motivation to choose the union's health insurance related to the adherence to the insurance chosen by the professors association ("It is the association's insurance for professors" -P2, P3 and P5 interviews) or "it is our insurance" (P1 interview). This consideration refers to the justification and adjustment mechanisms, suggesting a noble reason of belonging, despite acknowledging that the insurance is in fact not the best.

There is a clear difference perceived between professors with a lower scientific capital who mentioned few criticisms regarding the insurance and expressed a greater willingness to continue with it. In this group, the insurance choice ratio was more associated to the whole family being able to adhere. They are professors who are affiliated to the faculty association (APUB) for over 10 years. Professors of this group also reported only using the insurance's physicians and only in isolated cases, they seek personal physicians:

> *I was looking to make an appointment with a dermatologist, it was one of the hardest to find, because I had no indication... then an indication that I received, I found out that APUB didn't cover it, then I thought: 'well, if I have insurance* [...] *why would I go private?'. I asked my daughter 'make an appointment with a dermatologist for me'. She then found one, one in the same building of the gynecologist, close to my home* (P10, university professor, 54 years old, high global capital and low scientific capital).

As expressed in the following excerpt, the professor chooses the "medium", neither a "medallion" nor an "unknown". The choice of a medium reveals an adjustment of preferences to the objective conditions of the possibilities and a position that differs both from the top position as well as from that immediately inferior position – not the bourgeoisie or the proletariat: the middle class:

> *If you get a very good doctor, a big shot, you have a hard time getting in to be seen by him. But then you get a bad doctor, and that is also not good. So you have to take a medium one, which is neither a big shot, nor a bad one, to get to be attended and not be badly attended* (P12, university professor, 47 years old, high global capital and low scientific capital).

In contrast, the group of professors with a high scientific capital had many criticisms of the insurance used by the Faculty Association (APUB), and in one case, one professor decided to leave the insurance. Among the criticism, they pointed to the fact that the insurance did not cover hospitals regarded as luxurious in the city, certain procedures and tests taking too long or failing to be authorized, and not having physicians considered prestigious in their list of approved medical consults. Another professor uses the insurance only to conduct clinical and laboratory tests and in case of hospitalization. All physicians consulted by this professor are private, renowned ones, despite the insurance. These characteristics reveal among the group of professors with a high scientific capital, that which is called taste of luxury.

The degree of adjustment to renowned physicians is high, and patients are willing to accept without further questioning the opinions of these physicians.

The social creation of tastes and preferences often expressed through mirth (disgust, contempt) of "other's" values (representatives of opposite or social positions that are distant). Taste, thus, is revealed "by displeasure". The fragment below illustrates an example of this effect, in which tastes are revealed by opposing the tastes of other groups. The user, with a low global capital, but with a greater cultural capital (for the group), after making several complaints about the Brazilian Unified Health System (SUS), answers the interviewer about interest in owning a health insurance:

> [- Have you ever signed in on health insurance?] *God forbid! The health insurance doesn't cover everything, you get there, by the time the insurance authorizes you're already dead* [...]. *Because if you have to wait for it, by the time it authorizes... like I've seen many times* [...] I'd rather pay a private consult, I'd prefer to take some money so... to pay R$100 or R$150, but to see results, *rather than keep paying the insurance and when the time comes, I either don't have full coverage [...] So for me, I'd rather pay private care, to pay a consult, which is much better.* (E2, domestic worker, 37 years old, low global capital and medium cultural capital).

In the respondent's speech, we note again a situation of adjustment, in an attempt to differentiate the superior position (having health insurance) from the immediately inferior (can only use the public system – SUS). On the one hand, an attitude of superiority in relation to their group ("I pay R$200, 300") and at the same time a resentful attitude towards the disadvantaged social class (which may not have health insurances). The use of popular clinics is seen as a distinguishing mark between low global capital agents, revealing ascending strata of this class.

The rejection of the health insurance can also be interpreted as a form of practical materialism of the popular ethics, a philosophy compatible with those who have no future (Bourdieu, 2006). It largely differs from the sense of planning and orientation for the future that are typical of the middle and ruling classes, represented in this study by the decision of having a health insurance.

The differentiation operation between agents, distinction strategies, have proved to be regulated with close principles. Go to a renowned and private physician is a distinction strategy among university professors, as well as (popular) private clinics, which are used as merit badges by agents with a low global capital.

The ascetic *habitus* of professors results in high expenses with health care (Bourdieu, 2005). The notion that "health is priceless", and at the same

time, the monetization of care, seems to work as the logic. It is worth mentioning the story of a professor with medium scientific capital, who refused to buy generic drugs, preferring branded medicines from big laboratories. Concerns with health in this group are in the foreground and the costs with health insurances and medications were referred to, by most professors themselves, as responsible for a large portion of their monthly budgets.

The distance between the need for medical care and critical judgment of the services

The establishment of criticism also relates to the distance of the need for medical care. The greater the distance from the immediate need for care, the greater the willingness to criticize. On the contrary, the more one is frail or ill, the greater their medical dependence and the knowledge/power he or she holds.

The agents who are sick evaluate the relationship with their physician as greatly dependent. In such cases, even when the agent has a high cultural capital, the situation of fragility and dependence is imminent. The agents describe their situation as "having no choice", having no decision-making power:

> *I liked the way I was attended. They were very kind and competent. My doctor-patient relationship is a relationship of dependency. If you can find empathy, you surrender to it. What they say I have to do, I do it* [...] *When you are in a weakened position, you have no decision, you are in their hands... Right now Gisélia summoned me for a second cycle of chemotherapy. She asked: "So?", I asked, "I have a choice?". She said, "no, you don't". "So don't ask me". And I submit* (P3, university professor, 62 years old, high total capital and medium scientific capital, cancer patient).

Also present in another statement,

> *I do not have a lot of choice. When I'm sick, I don't understand my illness, so in principle I trust or try to trust* [the doctor] (P8, university professor, 46 years old, high global capital, low scientific capital).

Final remarks

The judgement on health care services is unequally distributed between groups and classes depending on the position occupied by the agents in the social space. The conditions surrounding the choice of physician by the agents with a high global capital, in this case university professors, occur not only due to the economic capital that allows them to pay for a private physician's appointment or to change their health insurance, but also due to the network of social relationships that allow them to choose and judge what would be the best physicians according to different technical or symbolic criteria.

In addition, the distance from a situation of suffering or illness also contributes to increase in the margin of freedom for choice and criticism. On the other hand, the universe of potentials for the popular classes is quite limited by economic and social contingencies.

This study contributes to the explanation of high user satisfaction reported by studies published in the literature for two reasons. First, to the extent that it analyzes the establishment of a "critical disposition" as the product of the social position of the individual, resulting from the accumulation of different capitals, especially cultural, as well as the social trajectory of the agents. The critical attitude of the middle classes ("enlightened" agents or high cultural capital agents) diverge from the sense of resignation and fatalism present in the popular classes.

The possibility of critical judgment of the physician was associated to the cultural capital of the user. Criticism of the physician are most prevalent among professors with a high global capital and medium and high scientific capital. Little criticism is given to the physician from the low global capital agents. The critical judgment articulates directly with the distance to the need for health care. Situations of diseases pose weaknesses and redouble their dependence to the medical figure.

Secondly, the study shows the adjustment of practices according to resources, as described by Bourdieu (2005). This adjustment, a non-conscious synthesis between needs and possibilities, is operated by the *habitus*, which explains the formation

of tastes and preferences, according to the universe of possibilities.

Thus, users with a low global capital, dependent on SUS, also find themselves in a position of great dependence and submission, adjusting themselves to the structure by using a set of awareness schemes that validate it. It is worth noting that the adjustment to the situation is not a thought out process, nor desired as such, in the sense of being a deliberate and rational choice.

The generalization of the study findings should be done with caution, given the limitations of the selected sample. Thus, as a future perspective, we suggest that more extensive population studies be performed, in which the evidence found in this study regarding the relationship between the judgment of users and their social position can be better validated. The consistency between the empirical findings and the theoretical framework, however, corresponds to a construct validity, which enables the development of an explanation for the paradox investigated, all by itself.

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Authors' contribution

Esperidião performed all stages of the research. Wrote and reviewed the entire article. Silva participated in the formulation of the research question, data analysis and writing of the article.

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