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Good health for all: an ethnographic study of frontline professionals in general and mental healthcare and social welfare

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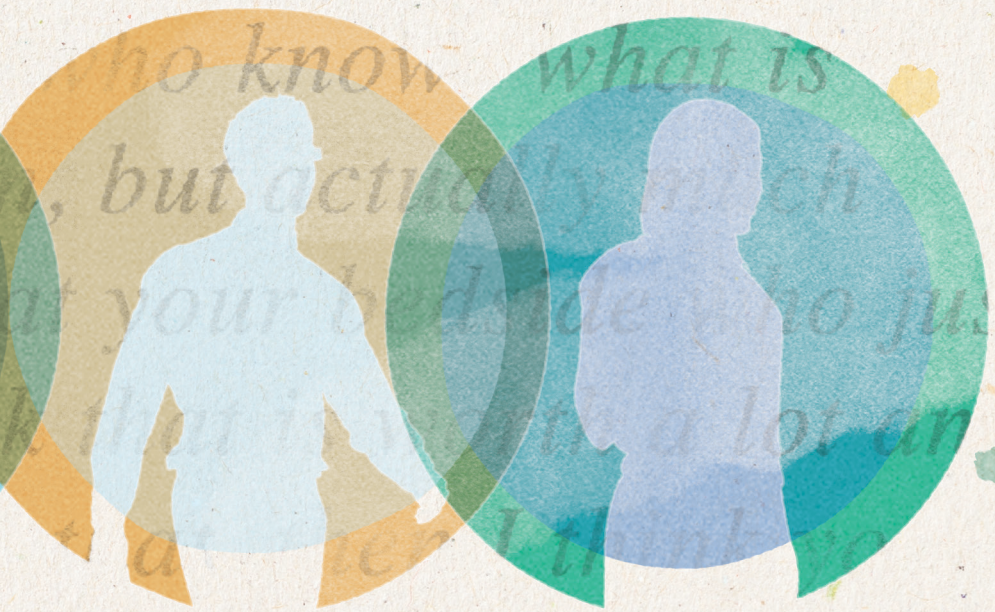
Chapter 5

What reasoning do frontline professionals use around citizen-clients' socioeconomic status: Exploring the mechanisms



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Abstract

This paper examines socioeconomic status (SES) as indicator for decision-making among frontline professionals in healthcare, focusing on general practitioners (GPs). Aside from research on stereotypes, we know little about how frontline professionals reason about SES in decision-making. This study addresses this gap by investigating how GPs use SES to develop care for patients with varying SES backgrounds. Based on qualitative interviews, the study identifies three SES reasonings which are closely intertwined with the status of patients: (1) status preservation reasoning describes how GPs interpret SES cues and status stability in relation to what needs to be preserved, (2) social distance reasoning helps explain how social distance creates a reference point when helping the patient, and (3) together reasoning describes how GPs use patients' busyness and educational level to develop treatment plans together with the patient. This study contributes to the existing literature by distinguishing SES reasonings in frontline professionals' decision-making.

5.1 Introduction

In caring for citizen-clients with combined psychosocial problems, frontline professionals work with people with different socioeconomic statuses (SES). The literature on street-level bureaucracy examines the role of SES in decision-making by frontline professionals, arguing that it is socially undesirable for people with different SES contexts to be treated differently in comparable situations (Harrits and Møller 2014, Raaphorst and Groeneveld 2018). People in certain social categories are more likely to have access to socially valued positions. For instance, children with lower social status tend to be devalued in school, not because they are less smart, but because teachers perceive them as less smart (van der Waal and de Koster 2015, van der Waal 2022). Notwithstanding the research into the use of stereotypes in decision-making, within street-level research in public administration (Raaphorst and Groeneveld 2018, Harrits 2019), there is still too little understanding of how professionals themselves work with differences in status among citizen-clients. Health sociology literature, on the other hand, addresses how frontline professionals use socioeconomic status as a category to justify differentiating among patients with specific needs (FitzGerald and Hurst 2017). Insights into the use of SES by GPs (General practitioners) are considered relevant for the work of SLBs (street-level bureaucrats) in general, because GPs operate at the frontline of service, making impactful decisions in direct interaction with citizen-clients, and having considerable discretion in doing so.

There is still a lack of understanding of the role of citizen-clients' SES in healthcare decisions. Therefore, our research question is as follows: *What reasoning do frontline professionals in healthcare use regarding cues associated with varying socioeconomic statuses?* This question explores the mechanisms through which frontline professionals, specifically GPs, interpret socioeconomic status cues when formulating treatment plans with their patients. By researching how GPs make judgments about patients with different socioeconomic statuses, we can deepen our insight into the role of SES in decision-making. We answer the research question by means of a qualitative interview study with GPs who, as frontline professionals, work directly with patients with combined psychosocial problems and encounter differences in SES on a daily basis. In our findings, we identify three SES reasoning mechanisms related to 1) status preservation, (2) the role of social distance in care, and (3) the ways in which professionals develop a treatment plan together with patients based on patients' busyness and educational level. Based on these findings, conversations can be initiated around the desirability of this approach.

This study makes three key contributions to the scientific debate. First, this study adds to existing research on the role of citizen-clients' SES in frontline decision-making (Harrits 2019, Harrits and Møller 2014, Raaphorst et al. 2018, Raaphorst et al. 2024). Existing research typically focuses on only one SES-indicator, such as citizen-clients'

level of education, or occupation, while the concept of SES consists of economic, social and cultural dimensions. Isolating one of the dimensions allows for assessing independent effects, but does not capture how different SES dimensions *together* are used to inform decision-making. Decision-making research often uses between-person designs and quantitative data (a.o. Halling, Christensen et al. 2024, although see Raaphorst et al. 2018 and Harrits 2019). While useful for uncovering biases, these methods do not reveal how SES indicators inform judgments about individual needs. Our pioneering qualitative within-person study in SLB research uses various SES indicators to achieve an in-depth exploration.

Second, street-level bureaucracy literature often highlights the downside of differentiating based on SES in similar situations (Harrits 2019, Raaphorst et al. 2018), while healthcare literature focuses on the positive side of responsiveness to different needs (Hamilton, Henderson et al. 2019, Hagger and Hamilton 2021). In fact, existing discrimination research provides indications that differences in citizen-clients' SES, such as level of education, in otherwise similar cases, *does* make those cases different for frontline professionals, indicating potentially different needs (e.g. Raaphorst et al. 2018, Raaphorst et al. 2024). This underlines that what constitutes 'equal cases' and 'different cases' is in the eye of the beholder. However, our understanding of the latter aspect remains limited. The present study aims to fill this gap by studying how GPs interpret different SES indicators in their judgments.

Third, much of the research on the role of SES in decision-making has focused on the differentiation mechanisms deployed by teachers, pedagogues and executive organizations (Harrits and Møller 2014, Raaphorst & Groeneveld 2018). This study focuses on the reasoning around SES among professionals who work with a diverse range of patients in terms of SES and place a strong emphasis on personalization: GPs working with patients with psychosocial problems. Focusing on GPs, who are primarily responsible for addressing patient needs, provides valuable insights into the role of SES in decision-making. In a highly professionalized context with significant autonomy, GPs may take SES into account in their decision-making — an area that remains under-researched.

In the following sections, we first present our theoretical framework, we then delineate the core concepts of this study, after which we describe our methodology and research context. We then present our findings and conclude with some theoretical and practical implications.

5.2 Differentiation on the basis of socioeconomic status

In this theoretical framework, we draw from literature on both street-level bureaucracy and health sociology to develop a theoretical understanding of the differentiation on the basis of socioeconomic status that frontline professionals bring to their decision-making. This theoretical framework uses the term 'frontline professional', because GPs are seen as professionals in frontline service, with the freedom to decide on appropriate care to meet their patients' needs (Lewis et al., 2003, McKenzie 2016).

Conceptualizing socioeconomic status

This study follows Van der Waal and De Koster (2015) in conceptualizing the separate dimensions of socioeconomic status. The authors argue that the existing literature is not always explicit as to what socioeconomic status entails, and that it is much more than education or income alone. In this study, socioeconomic status is conceptualized as a combination of economic, social, and cultural dimensions. Including these three dimensions in our conceptualization enables us to study how SES is used as a way to differentiate citizen-clients' needs.

The conceptualization centers on the distribution of economic, cultural, and social resources. In Bourdieu's approach on capitals (1984), professions are hierarchically ranked based on their labor market value. Indicators of *economic status* include whether someone is employed, how well they are paid, and whether they have economic resources (Vrooman, Boelhouwer et al., 2023) such as money. *Social status* is defined as the total of existing or potential resources as a result of possessing a more or less institutionalized network of social relationships. Social networks are never a given, and relationships and networks require ongoing investment and maintenance (Bourdieu, 1984, Engbersen, 2003). More social resources could be potentially valuable, and they could therefore also be hierarchically ranked. A person's *cultural status*, includes lifestyle, knowledge, cognitive capacities and education, which can be hierarchically ordered in terms of prestige. Cultural status can be used to obtain and maintain social privileges. A specific lifestyle is expected from people belonging to a certain cultural group (Weber 2009, van der Waal and de Koster 2015). The lifestyles of certain cultural status group are displayed, embraced and propagated by those belonging to other cultural groups. However, while some people may recognize other lifestyles as 'the way things should be', these lifestyles are not necessarily internalized by other cultural groups (Bourdieu 1984, Brinkgreve, van den Haak et al. 2011, van de Waal and de Koster 2015).

SES as ground for discrimination of otherwise similar cases

Two different fields in the literature consider how frontline professionals take citizen-clients' SES into account. First, street-level bureaucracy literature specifically focuses on the role of SES in decision-making by street-level professionals. It is considered so-

cially undesirable for people with similar situations but different SES backgrounds to be treated differently (Harrits and Møller 2014, Harrits 2019, Raaphorst et al. 2018). Second, health sociology literature addresses how frontline professionals justify making desirable distinctions between citizen-clients based on SES. The underlying assumption of this field of literature is therefore that individuals from different SES backgrounds potentially have different needs, and require distinct approaches. This type of research is particularly prominent in healthcare, because SES indicators influence how interventions play out, and healthcare researchers argue that we need to differentiate between citizen-clients based on SES indicators (Hamilton, Henderson et al., 2019 Hagger and Hamilton 2021). However, we still have limited understanding of the latter phenomenon.

Street-level bureaucracy research into SES mainly focuses on how similar situations are treated differently based on, among other things, stereotypes related to SES. These studies are designed using comparable personas and manipulating SES indicators to investigate differences in evaluation (Harrits, 2019, Harrits and Møller 2014, Raaphorst et al. 2018). These studies also indicate that SES indicators are sometimes explicitly used to gain insight into, for example, the competencies and intentions of citizen-clients that are relevant for decision-making. This suggests that differences in SES, such as level of education, in otherwise similar cases, *does* make those cases different for frontline professionals, indicating potentially different needs (e.g. Raaphorst et al. 2018, Raaphorst et al. 2024).

Street-level bureaucracy research shows diffuse patterns as professionals sometimes more positively evaluate clients with higher SES, and sometimes those with lower SES (Harrits and Møller 2014, Harrits 2019, Raaphorst et al. 2024). For instance, using a vignette experiment, Raaphorst, Ashikali and Groeneveld (2024) find that citizen-clients with higher educational levels are assumed to have more knowledge of the rules than those with lower educational levels. In line with this, Raaphorst, Groeneveld & Van de Walle (2018) find that higher educated citizen-clients avoiding contact are evaluated more negatively than lower-educated citizen-clients avoiding contact. These studies indicate reverse forms of discrimination, whereby the citizen-client with a lower level of education is evaluated more positively than higher educated citizen-clients. Other research indicates that frontline professionals explicitly reference social categories when describing their concerns about citizen-clients (Harrits and Møller 2014). Harrits and Møller (2014) show how frontline professionals' worry about citizen-clients seems to increase when social distance between the professional and citizen-client increases.

SES as ground for responsiveness to potentially different needs

Health sociology studies on the role of SES indicators show that they are used to differentiate between patients, potentially indicating different needs (Hamilton, Henderson et al. 2019). This research does not usually use the concept of SES, but refers instead to sep-

arate dimensions, such as lifestyles. This research is characterized by a growing interest in personalized healthcare. According to this literature, which mainly originates in the Netherlands, healthcare personalization operates from the principle of responsiveness to provide citizen-clients with the best assistance possible (De Blok, Meijboom et al. 2013, Bartels, Meijboom et al. 2021). In healthcare, the approach to categorizing patients based on their attributes has evolved with the emergence of personalized and precision medicine. These advancements aim to mitigate disparities among populations by considering individual lifestyles, thereby aligning with patient-centered care principles. Research in health sociology examines the interplay between lifestyle behaviors, social variables such as age, educational level, gender and income, genetics, environmental factors, and personalized healthcare strategies. This literature indicates that various SES dimensions relate to health behavior through lifestyle, offering normative recommendations on the best approaches for addressing these factors (Noordman, Verhaak et al. 2010, Berenguera, Pons-Vigués et al. 2017, Hamilton, Henderson et al. 2019, Hagger and Hamilton 2021). For example, Hamilton (2019) discusses how GPs take responsibility for discussing lifestyle with their patients. The decision to discuss lifestyle during a consultation is reported to be ad hoc and unsystematic, which means that there is no standard procedure regarding lifestyle advice or when to refer a patient to other professionals for lifestyle interventions. It is therefore unclear which reasoning GPs use to decide whether to offer lifestyle advice. Nevertheless, the literature suggests that patients' lack of understanding and low levels of health literacy may lead to professionals being more or less likely to bring up lifestyle changes (Hamilton, Henderson et al. 2019). Most of the literature in this field does not address how these lifestyles are then used to determine an appropriate healthcare plan (Lin, Chen et al., 2017).

Despite extensive exploration of socioeconomic dimensions and GP-patient interactions in health sociology research, most of these studies point to one or two SES indicators to explain patient-physician interactions. For instance, Willems et al. (2005) show that patients from lower SES elicit less positive socio-emotional communication and more directive and less participatory consulting styles from their doctors. Doctor's communication styles are influenced by the communication patterns of patients from high and low SES groups. In addition, such studies often do not explain why these particular indicators, such as educational level, income or occupation, are the relevant SES dimensions (Willems, De Maesschalk et al, Allen, Rogers et al. 2019). Health sociology literature posits that the premise of personalized healthcare is based on GPs' responsiveness to patients' lifestyle, which is an integral component of SES. Although some studies report positive and negative effects of personalized and customized approaches in healthcare, there is too little insight into the specific dimensions through which SES is used to inform judgments about needs (Minvielle, Fourcade et al., 2021). There is still a gap in our understanding of the reasoning GPs use when addressing SES and how social,

cultural and economic dimensions play a role in their decision-making (Bourdieu 1984, van der Waal and de Koster 2015). This study therefore investigates the reasoning GPs use around SES cues to identify potential differences in needs. In other words, we aim to understand how SES is used by frontline healthcare professionals to differentiate and recognize varying needs. This approach underscores the role of SES dimensions in personalization, identifying how GPs tailor their care based on their patients' diverse SES backgrounds.

This study generally defines reasoning as the mental process of drawing conclusions, making inferences, or evaluating arguments based on available information and logical principles (Mercier 2011, Mercier and Sperber 2011, Toplak, West et al., 2014). In this study, the authors focus on the latter by inductively examining the reasoning of professionals about individuals, and how SES dimensions are used in this reasoning to decide on treatment plans that match the patients' needs.

5.3 Methods

The issue of the reasoning used by professionals around cues associated with variations in socioeconomic status is best explored using a qualitative within-person design. The data in this study stem from qualitative interviews with GPs using personas as a method of data collection and analysis (Harrits and Møller 2021).

Context and research focus

The Dutch healthcare system is known for its accessibility, quality, and efficiency. GPs act as the first point of contact within the Dutch healthcare system. Patients have to first consult their GP before they can be referred to specialized care. In the Netherlands, GP is a highly professionalized profession with a lot of autonomy. This is due to the fact that GPs undergo a minimum of 9 years of training, it is a protected profession and there is a dedicated disciplinary board that oversees the conduct of practice of GPs (General Practitioner Training, 2025[4]). The idea is that GPs provide continuity of care, which means that they guide patients for long periods of time and have an overall understanding of their medical history, which in turn ensures a personalized and effective treatment. Apart from treating illnesses, GPs are also responsible for preventive care. They offer advice on healthy lifestyle, and screen for early detection of diseases (NHG, 2025).

This study was carried out in The Hague, the third largest city in the Netherlands. This was a strategic decision because psychosocial problems are disproportionally

4 This is an informative website by the General Practitioners Training the Netherlands aimed at providing official information about general practitioner training.

common in some parts of the city, particularly among low-income residents, and there are substantial differences in the socioeconomic status of the population (Haaglanden 2021). To guarantee internal validity, this study focused on GPs working in neighborhoods in which combined psychosocial problems were most apparent. Moreover, GPs increasingly have to deal with psychosocial problems, or a combination of physical, psychological and social problems, which are multiple, diffuse and can be seen as ambiguous. This expansion of health problems places greater pressure on GPs (Hadoks 2023) and these problems can often be interpreted differently and subsumed under various care domains. Importantly, GPs are the first frontline professionals to interpret patients' problems and build a relationship with patients with high levels of discretion. This happens in a context of personalization in healthcare in which GPs share the objective of collaboratively organizing care as much as possible within primary care (Hadoks 2024a). Given the variation in patients' SES backgrounds and the growing emphasis on personalization, there are good reasons for examining the SES reasoning of GPs. GPs in our sample have between 1 and 35 years of experience in this profession and their ages range between 30 and 65 years old. Most GPs identify with higher SES groups, while some have backgrounds in lower SES groups.

Methods and data

Interview study approach

In order to examine how professionals assess the psychosocial problems of citizen-clients with varying statuses, a qualitative interview study was conducted with GPs to mimic real-life decision-making by using personas to which respondents were asked to react. Similarly to vignette research, the authors used personas as stimulus material to start a conversation about attitudes, values, perceptions and judgements in decision-making, thus using them as tools for an in-depth analysis of these processes (Loyens and Paraciani 2023). Persona refers to text, images or other expressions used to describe a situation or individual that can be used as stimulus to prompt responses to interview questions (Hughes and Huby 2002). Personas also elicit 'second stories', meaning that if we know what topics are worth telling a story about, the next question triggers storytelling, also beyond the persona (van Hulst and Ybema 2020). Second stories emerge because first stories remind respondents of previous experiences (ibid.). Personas are hypothetical but realistic descriptions of situations that resemble the respondents' daily experiences (Wilks 2004). The personas in this study all somatically describe the same problem, but their SES context is different, which may lead respondents to conclude that their problems are different, also somatically.

For this study, three personas (see Appendix D1) were constructed during ethnographic fieldwork by the lead author, which strengthened the internal validity of the personas (van Heteren et al. 2024). The personas are therefore hypothetical, although

they are based on real GP-patient interactions (Hughes and Huby 2004). Respondents were asked to reflect on the three personas, all of which represented patients with a combination of psychosocial problems. All personas presented the same expressed health problem, namely pain in the chest, but with slightly different socioeconomic status cues. The high SES persona was a male lawyer who, due to stress-related complaints, did not spend as much time with his friends as he would have liked to (Engbersen 2003). He had a well-paid and highly educated job (Abel 2008). The low SES persona was an uneducated male who was temporarily on sick leave, was insecure about his financial situation, and was an informal caretaker for their partner (Abel 2008). He frequently cooked his meals in an air fryer, a choice often associated with lower SES individuals (Kamphuis, Jansen et al. 2015), and did not have a stable social network (Engbersen 2003). The mixed SES persona was a male with a mix of high and low SES indicators. This person worked as a freelance handyman, was close to his family, had a busy life, and sometimes smoked marijuana with friends to fall asleep more easily. This persona combined lower and higher SES cues, since smoking is often associated with lower cultural status individuals (Mariël, Schrijvers et al. 2002), while having friends and family is linked to higher social status (Engbersen 2003), and having a job is economically valued (Vrooman, Boelhouwer et al. 2023). He is also financially successful in his business, but he did not finish high school (Abel 2008). The authors assume that since SES cues are interrelated, they all affect how the persona, their health and the required healthcare plan are interpreted (Abel 2008). To avoid hierarchically ranking people's cultural lifestyles as researchers, the authors let the respondents decide what the SES cues pertained to and whether they concerned a high or a low status. Neither the researcher nor the persona explicitly stated this during the interviews; this was merely implied, for example, by referring to the type of work someone did, their educational background, their social network, or their lifestyle. To further enhance the personas' internal validity, they were tested in three pilot interviews with GPs and in conversations with GP colleagues from the lead author's department. The latter ensured that the personas elicited the type of response the authors were interested in, and that participants were triggered by the cues integrated in the personas. In other words, the resulting personas were plausible, authentic, and engaging, and they elicited vivid responses (Harrits and Møller 2021). After consulting experts, the authors concluded that chest pain could be interpreted in various ways, and that the level of concern and the development of a treatment plan could be directed at different aspects of the problem. Among males aged 40 to 50, chest pain could be a physical problem, but it could also be interpreted differently, as a stress-related problem. The problem is ambiguous enough to study potentially different interpretations based on patients' SES backgrounds. Another element that contributes to the transparency and traceability of our findings is the code table provided in Appendix D2.

In the analysis of this study, reasoning included the professionals' initial interpretation of the complaint, the interpretation of cues in reaching a decision about the

patient, the level of concern, and the development of a treatment plan. Reasoning about SES information may lead to a certain level of concern for the patient. The level of worry a GP experiences about a patient and the aspects of the persona they are most worried about are relevant: is the GP worried about the patient in general, or about specific aspects in or beyond the persona, and what kind of further decisions regarding a specific treatment plan do these worries lead to (Harrits 2019)? Existing research often focuses on the final decision, but in our study, reasoning revolved around the process of interpretation rather than the final level of concern (Harrits 2019). This study was registered and approved by the Medical Ethical Review Committee of Leiden, The Hague and Delft (N20.158) and consent was given by all respondents.

Data collection

Data collection took place in 2023. Prior to the interview, respondents were asked to share some information about themselves: In what circumstances did they grow up and how would they describe their own social status? How do they see themselves as a professional? What do they find important in their work? How do they view their work context? (see interview guide in Appendix D1). Respondents were then asked to read the different personas and the researcher asked them some open questions about each persona. The interview finished with reflection questions to help understand how the respondent arrived at their reasoning and how they compare their interpretation of the three personas. Why did the respondent choose different strategies for different patients? And how and why did their level of concern differ? These open questions helped respondents to think aloud and talk freely about their interpretation of the personas from their own perspective.

All 15 interviews lasted from 45 to 90 minutes, and they were audiotaped, transcribed verbatim, and coded using thematic analysis, including open, initial, and closed coding (Braun and Clarke 2006, Charmaz 2006). We translated all the quotes below from Dutch, and in doing so tried to reflect the original wording as accurately as possible. We used pseudonyms to protect the respondents' privacy and omitted any reference to the neighborhoods where they worked. Respondents were recruited by contacting GPs within the lead author's research network. All were purposefully selected as GPs working in neighborhoods where combined problems are most apparent. Additionally, the snowball sampling method played a key role in recruiting further respondents.

Analysis

This research study uses an abductive approach, moving back and forth between theory and data (Schwartz-Shea and Yanow 2013, Tavory and Timmermans 2014). We therefore approach the empirical world with theory on socioeconomic statuses and frontline professionals' standards for evaluating citizen-clients. Our analysis did not focus on comparing responses to the various personas, but rather on the reasoning about the

individual personas based on respondents' values and interpretations of SES cues. The problems experienced by the personas were similar, but the SES dimensions differed. We coded the interviews using constant comparison (Glaser and Strauss 2017) and sensitizing concepts relating to the three dimensions of socioeconomic status to identify relevant aspects of the data. The first step was to look at which cues respondents used in their reasonings. In their reasoning, respondents could for instance refer to status cues when talking about their initial interpretation of the persona. The second step was to look at how respondents reason around status cues, and what kind of reasonings they use. For example, their reasoning towards a specific level of concern and treatment plan. The third step was to look at which socioeconomic dimensions the respondents use in their reasoning. How did they differentiate between socioeconomic status dimensions and how did they refer to these dimensions in their reasoning about the citizen-client explicitly or implicitly? (See appendix B for quotes and initial interpretation). This type of analysis is relevant in this context, because GPs are highly professionalized in the Netherlands, but they also use their intuition or gut feeling in working with patients. The authors used the empirical insights to further explore the relevant literature and refine the analysis accordingly. We conducted peer validation during the coding process and the second author was closely involved in the coding process.

5.4 Findings

Conceptualizing SES reasoning

The authors conceptualized three different types of SES reasoning and explored their mechanisms: The findings focus on how reasoning occurs, taking into account status preservation, social distance and developing a treatment plan together with the patient through various mechanisms. An overview of these findings can be found in table 5.1.

Status preservation reasoning around SES

The first type of reasoning, status preservation, focuses on how GPs try to preserve their patients' status dimensions based on their SES. This type of reasoning is characterized by how GPs use various status cues to assess which dimensions need to be preserved.

The following example from respondent 4 shows what status preservation reasoning around SES looks like:

> ***'Suppose he relapses [with his burnout], he will lose a lot.'***
>
> *'The second [high SES] one is really in big trouble, and it will take a long time before he gets out of it, I think. He might be the most difficult, the most time-consuming, to get back on his feet. [...] With a bit of luck, the*

third [low SES] patient can move on with a minor intervention. If he can be reassured and find his strength again. [...]And if he can get some guidance on how to handle [his partner][...], it might be possible for him to return to a stable situation. [...] The first [mixed SES] man just keeps going. So far, he hasn't hit any obstacles. If we can get him to calm down a bit, he might make it much further without any problems. Socially, he has no issues... his work is going well. I don't see a decline happening here. With the second [high SES] man, his work is not going well, which is worrisome for a lawyer. And with the third man, his work is also not going well. But that is not the most important thing here. The difference between working and not working is not very significant for him in terms of income. So, in that respect, you can easily create some space and calm by keeping him on sick leave a little longer if necessary. Until the other issues are resolved. [The high SES man has risk of] social decline. Suppose he relapses [with his burnout], he will lose a lot. And then many small things can start to unravel. He might get into trouble with his partner, or at the very least, his self-esteem will take a huge hit.'

Respondent 4 therefore shows that in practice, the status preservation reasoning is a combination of SES indicators and perceived stability. GPs therefore look at various SES cues to decide what patients might lose if they become unstable, and they try to assess whether patients are stable.

GPs emphasize the importance of preserving various SES dimensions to prevent overall decline. They highlight the need to maintain social status, including relationships with friends and family, as well as economic status, such as having a stable income. GPs argue that cultural lifestyle cues, such as hard work and care responsibilities, have an impact on patients' stability. At the same time, GPs emphasize the importance of preserving cultural lifestyle, including self-esteem through work alongside other dimensions. In other words, GPs argue that certain patients should be able to hold on to their higher cultural lifestyle, possibly making it harder to solve their issues. In doing so, GPs often mention the cultural lifestyle indicator as being important, because it could determine whether a patient can keep living the way they do without losing other status dimensions.

Social distance reasoning around SES

Social distance reasoning around SES is about how the GPs' and patients' SES affect the development of treatment plans. Characteristic of social distance reasoning is that some GPs use their own status or a status they are familiar with as reference points in developing treatment plans. The social distance reasoning mechanism means that the GPs' reasoning from a small social distance show identification with the patients' needs,

due to recognition of or feeling closeness to a similar status group. Small social distance reasoning is illustrated in the example below by respondent 1:

'***And I think of myself. As I said, I'm also quite active [...].***'

'*Sometimes it's not entirely [...] logical, but it's about the part where he says: "What I find unfortunate is that I can no longer do fun things in the evening with friends, like play badminton or go to a party. I enjoy spending time with my friends." So, then I think: it's not okay that that's not possible. And I think of myself. As I said, I'm also quite active and I get a lot of energy from it. But sometimes I also feel that my life is a bit too busy, so I can easily imagine that it causes stress if you have such a full schedule. When other people look at my schedule, they often say: "How do you do it? It would stress me out." I don't know. Somehow, I'm suddenly thinking about that... [...] But there is something that makes me think: No, I don't think it's right that all that is no longer possible, so I find it alarming. I don't even necessarily know whether that means he has a heart condition.*'

Respondent 1 therefore shows that in practice, this mechanism means that GPs who recognize a patients' cultural lifestyle as similar to their own aim to help the patient to get their life back in order. GPs personally understand the importance of helping this patient, because they are able to identify with the patient.

While the first example of small social distance reasoning focused on the high SES persona, this mechanism also arises in situations where both the GP and the patient have or have experience with being in other than high SES positions, as illustrated by respondent 10:

'***I do know what it's like to be different [...].***'

'*At some point, we lost our expat status and then we just became foreigners [in the Netherlands]. [...] We were placed in a Dutch school and gradually moved out of that [expat] world. [We] survived here as best we could. [...] I was also on the receiving end of prejudice and all sorts of things. So, I'm a bit between two worlds in that respect. [...] I do know what it's like to be different and I know what it's like not to always have it easy, I know what it's like to have to fight for where you want to get to. But I've come a long way... [...] In general, in patient care, I try to take on a more empowering role. I want to give people more power over their own health, so they can take care of themselves, and we don't always have to do everything, because that's not necessarily realistic either. [So,] providing a lot of information,*

a lot of explaining, always saying why we do or don't do something. [...] I like to take the time, where I can, for someone, if they need it. And I think I also look – but I think that's part of the job – but I look more broadly. So, I take into account... I mean, you often see that it's not just the illness, but a lot of other things too.'

Respondents thus recognize the feeling of being 'different' because of their own status background. Identification with the patient makes it easier for GPs to get patients the treatment they deserve, similar to those in higher SES situations. GPs thus see a clear course of action ahead. This social distance reasoning is therefore not only activated by GPs' current status, but also by experiences in other SES positions from the past.

As this section shows, in small distance reasoning around SES, GPs mostly consider cultural status as an important dimension in recognizing their patients' status. GPs recognize the importance of this dimension for their patients, because they also find it important in their own life.

Together reasoning around SES

Together reasoning around SES is about how caring develops, and it describes how GPs use different approaches to working more or less collaboratively with a patient, based on their SES characteristics. Characteristic of together reasoning is that GPs use different approaches for formulating a plan with the patient. Specifically, GPs may decide to formulate a plan together with some patients, while with others, they may decide to formulate a plan for the patient, or let the patient decide about the plan. The core of together reasoning around SES is that GPs respond to the patient's perceived self-sufficiency, based on how busy their life is and their perceived cognitive capacity. In this mechanism, how busy a patient's life is affects the GP's perception of their self-sufficiency and, consequently, the treatment plan. However, this reasoning only arises in combination with the GP's interpretation of the patient's educational background, because a patient's educational level could determine whether the patient understands the type of care they may need.

The following quote from respondent 11 illustrates how together reasoning around SES works.

'That also really influences how you assess someone's health.'

'This [...] [low SES persona] understands very little, so you really have to take him by the hand. That also really influences how you assess someone's health. [...] The other man, he's a lawyer, he's also very cognitively engaged. [...] He will understand me when I make a plan, he's also probably articulate enough to talk back.'

In together reasoning, busyness is therefore mobilized to decide whether a patient's problems need to be resolved quickly so they can get on with their lives. More specifically, this occurs when patients who are understood to have a high educational level. In other words, when being busy and having a high educational level are combined, the patient's ideas on the treatment plan are given priority, and the patient is invited to take the lead concerning the direction in which they want the treatment plan to go. However, when a busy life is not combined with a high educational level, GPs often see busyness as a factor that can cloud the patient's judgement, making it impossible for them to decide on the treatment plan themselves. Therefore, GPs are likely to decide that these patients need more guidance in developing a treatment plan.

GPs refer to a combination of cultural cues to explain their reasoning around the extent to which a patient is able to devise a treatment plan or needs assistance in doing so. The together reasoning mechanism is therefore triggered by a combination of two different cultural cues.

Table 5.1. Three types of SES reasoning and their mechanisms

SES reasoning of GPs		
SES reasoning	**Substantiation**	**Mechanism**
Status preservation reasoning around SES	How status is preserved in relation to SES dimensions	How the need for status preservation is determined by combining SES indicators and interpretations of patients' stability
Social distance reasoning around SES	How social distance is used to develop a treatment plan for patients	How small social distance creates recognition and a reference point when helping the patient
Together reasoning around SES	How approaches to creating a treatment plan are explored together with the patient	How patients' busyness and educational level is used to determine the development of a treatment plan

5.5 Concluding discussion

This study explored the reasoning used by frontline professionals in healthcare regarding cues associated with varying socioeconomic statuses. Our findings are that GPs use three types of SES reasoning in shaping their approach to patient care. The first type of reasoning, status preservation, refers to the way GPs determine the need for status preservation by combining SES indicators and interpretations of patients' stability. The second type of reasoning, social distance, refers to the way in which small social distance creates recognition and a reference point when developing a treatment plan for

patients. Third, together reasoning around SES reveals how GPs use patients' busyness and educational level to determine the extent to which they develop treatment plans together with the patient. This last finding helps to explain how SES plays a role in the extent to which and the ways in which professionals invite citizen-clients to share their preferences and take these into account in formulating a treatment plan (van Heteren et al, 2023).

This study contributes to the existing street-level bureaucracy literature on SES in decision-making, which shows limited insight in SES reasoning, by providing insight into grounds for differentiating between citizen-clients. Our study contributes to this literature, conceptualizing SES reasoning among GPs by examining what reasoning GPs use when considering cues associated with varying socioeconomic statuses. Our conceptualization of status preservation reasoning around SES is useful for theory development on the role of SES in decision-making because it enhances our understanding of the reference points that may impact professionals' deservingness judgments and resource allocation. Our conceptualization of social distance reasoning adds to the literature on social distance (Groeneveld and Meier, 2022;, Harrits and Møller, 2014) by showing how differences in social status between professionals and citizen-clients matter for decision-making. Harrits and Møller (2014) find that the larger the social distance between professional and citizen-client, the more worry is expressed and interventions suggested. Corroborating these findings, our study shows how social distance is also a type of reasoning, where frontline professionals draw on their own status positions to identify with citizen-clients in similar positions. Our conceptualization of together reasoning highlights a potential bias in decision-making whereby citizen-clients with higher SES may receive more collaborative care compared to those with lower SES. These insights contribute to theory development on the role of citizen-clients' SES in decision-making by frontline professionals.

Our conceptualization of different types of SES reasoning could also be relevant to the literature on administrative burdens. The literature on administrative burdens explains how status background influences citizen-clients' experiences and their responses to these burdens (Christensen, Aarøe et al., 2020; Döring 2021; Masood and Azfar Nisar, 2021). The varying resources individuals possess for coping with administrative burdens stemming from interactions with the state may affect them differently (Döring, 2021). Existing research has shown how street-level bureaucrats play a key role in perpetuating social inequity by enforcing seemingly neutral rules that disproportionately burden certain groups (Maynard- Moody and Musheno, 2012; Moynihan, Herd et al., 2015; Nisar, 2018). However, our findings show that SES also plays a role in how professionals take citizen-clients' background in account in determining the type of assistance citizen-clients may need, and the grounds on which they may need this. For instance, while GPs see some patients as self-sufficient, other patients are more likely to elicit a desire to relieve them of the burden of figuring out how to solve their problems. In practice, however,

the patient perceived as being self-sufficient may actually experience this as a burden, while the other patient may want to think for themselves.

Health sociology research on health inequalities argues that cultural capital is used to translate social inequality into health inequality through individuals' behaviors, attitudes and choices (Abel 2008), but there is a lack of research into how lifestyle approaches are implemented in healthcare (Minvielle, Fourcade et al., 2021). Our findings contribute to this literature by providing insights into how cultural status and other SES dimensions play a role in decision-making processes, with the aim of helping those in need. Central to our findings is that GPs focus on lifestyle indicators to tailor their personalized interventions. While such personalization in care seems crucial for some individuals, it is potentially problematic in that what one person perceives as personalized care may be interpreted by another as discrimination.

This research study has limitations that require reflection. One limitation is that we relied exclusively on qualitative interviews, using personas as conversation starters. While these rich narratives provide insights into the thought processes of frontline professionals and their reflections beyond the personas, they are not suitable for studying the professionals' reasoning in actual practice. This study sheds light on how GPs reason around SES in formulating healthcare plans with citizen-clients. However, this study does not give insight into how GPs mobilize professional — and other types of — knowledge in their reasoning. More specifically, in our findings, we show the mechanism of social distance reasoning, but we do not know where it comes from. Therefore, why respondents use this social distance reasoning could be because of motivation or personalized care, but it could also have to do with bias. Future studies could build on this by incorporating participant observations and experiments for studying professional behavior in various situations and to gain insight into knowledge mobilization (Møller 2022). Another limitation is the study's focus on a specific type of frontline professional, the GP. We chose GPs because they work specifically to address patients' needs, and they have significant autonomy in decision-making, as well as discretion, and extensive information about patients through personalized and often long-term relationships. This highlights the multifaceted and impactful nature of GPs' work, and distinguishes them from other street-level professionals, who may not have such an extensive range of characteristics. Future research should compare SES reasoning across different types of professionals in various domains to develop a general theory on SES reasoning among frontline professionals. Moreover, future research on administrative burdens could delve into how the use of SES reasonings by frontline professionals relates to the experienced burdens of citizen-clients' with different status backgrounds. Finally, this research study was carried out in a specific country context, and we wish to acknowledge that if this research was to be done in another country, different personas, inductively based on this alternative context, would be more appropriate.