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SOCIOECONOMIC STATUS AND HEALTH INEQUALITIES IN DISTRICT OKARA

Saeed Ahmad
MPhil Scholar Department of Sociology
University of Okara
Email: saeedahmaduo01@gmail.com

Dr. Shahzad Farid
Assistant Professor Department of Sociology
s.farid@uo.edu.pk

Sadia
MPhil Scholar Department of Sociology
University of Okara
sadiauos888@gmail.com

Abstract

Health inequalities have been a persistent and challenging issue across the globe, with significant impacts on individual well-being, healthcare systems, and society at large. This descriptive quantitative study examines the association between socioeconomic status (SES) and health disparities, focusing on the complex relationship between unequal distributions of health outcomes among people of district Okara. Non probability random sampling used to access the respondents (N=350) the results of the study showed that individuals with high socioeconomic status have lower health inequalities. However, the individuals with lower socioeconomic status have high health inequalities.

Introduction

Socioeconomic status (SES) refers to an individual's or a group's position within a social and economic hierarchy, typically based on income, education, occupation, and wealth. It is a significant determinant of health outcomes and is often referred to as the socioeconomic status of health. The socioeconomic status of health is a concept that highlights the correlation between an individual's social and economic standing and their overall health and well-being. Numerous studies have shown a strong association between lower socioeconomic status and poorer health outcomes across various dimensions, including life expectancy, disease prevalence, and access to healthcare. Socioeconomic conditions and health disparities socioeconomic status (SES) plays a crucial role in shaping individuals' and communities' health outcomes and overall well-being (Bauer Brand & Zeeb, 2020).

A significant portion of the study on people's engagement with the healthcare system has concentrated chiefly on individual attributes such as their health condition, insurance provision, and socio-demographic factors, including age and income. Recently, there has been a growing interest in the influence of contextual elements, which go beyond individual considerations. For instance, research has shown that the social and economic factors of a person's residential area are linked to their likelihood of having a regular source of healthcare (Litaker, Koroukian, & Love, 2005). Furthermore, Law et al. (2005) discovered that the location (neighborhood) impacted physicians' consumption of healthcare services and the presence of unmet healthcare needs. They also observed that the influence of location on healthcare utilization varied between males and females. According to Kirby and Kaneda (2005), there is evidence that living in a socioeconomically disadvantaged area is associated

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with a lower likelihood of having a regular healthcare provider and obtaining preventative treatment. It is also linked to a higher likelihood of unmet healthcare needs. The increasing interest in community-level features and their correlation with health and healthcare is seen in investigations that connect individuals' healthcare usage and more significant social and economic issues. Social capital refers to the tangible and intangible resources that individuals in a social group acquire via their social interactions. It is considered a feature of society and has generated significant interest among public health academics and policy-makers. A growing number of concerns are emerging, namely about the inconsistent and unclear definitions of social capital and the lack of clarity surrounding how it directly affects health. According to Leeder and Dominello (1999), some argue that ambiguity makes the concept "dangerous." Labonte (1999) further suggests that it should be addressed carefully due to its possible strategic significance.

Socioeconomic status (SES) refers to an individual's or a group's position in society based on various factors such as income, education, occupation, and social standing. It is widely recognized that socioeconomic status significantly impacts an individual's overall health and well-being, leading to health inequalities. Health inequality is the unequal distribution of health outcomes among different socioeconomic groups or populations. It implies that individuals with lower socioeconomic status are more likely to experience poorer health compared to those with higher socioeconomic status. The objectives of the study are below

- Assessing the association between socioeconomic status and health outcomes in District Okara:
- Analyzing healthcare utilization patterns and access to healthcare services
- Identifying social determinants of health that interact with socioeconomic status
- The study will investigate how socioeconomic status influences health behaviors and lifestyle factors in District Okara.
- Identifying policy implications and interventions for reducing health inequalities

Literature of Review

Socioeconomic inequalities in mortality rates in old age in the World Health Organization Europe region. This study explores socioeconomic inequalities in mortality rates among older people, highlighting the persistent disparities in health outcomes across socioeconomic groups (Srivastava, Chauhan & Patel, 2021). Socioeconomic Status and the risk factors as determinants of premature mortality: A multicolor study and meta-analysis of 1·7 million men and women. This meta-analysis investigates the association between socioeconomic status and premature mortality, emphasizing the role of socioeconomic factors as determinants of health inequalities vWilkinson, 1997). The study examined the relationship between education, a critical socioeconomic indicator, and mortality rates, highlighting the disparities in mortality based on educational attainment—socioeconomic inequalities in old age in the World Health Organization Europe region (Mackenbach, 2018).

The residential areas where people reside serve as a context that influences their social interactions (Diez Roux & Mair, 2010). According to research by Buka et al. (2001), residents of low socioeconomic status (SES) neighborhoods are more likely to witness or experience violence. A direct, linear relationship may be shown between family wealth and the probability of seeing or suffering violence (Crouch et al., 2000).

Elevated levels of violence within a neighborhood might also alter the social dynamics among its residents. Due to fears of violence, people may be less inclined to leave their homes, resulting in a decreased familiarity with their neighbors. People exhibit reduced levels of trust in societies characterized by prevalent violence. Research indicates that persons in

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low-SES neighborhoods are more inclined to believe that people are untrustworthy, unlikely to provide aid to others, and prone to exploiting others if given a chance (Sampson et al., 1997).In other words, impoverished neighborhoods have a lower degree of social capital, which means there is less cohesiveness and trust among community people and less desire to contribute to shared community objectives (Coleman, 1988) Neighbors are also less inclined to participate in informal social control, which refers to enforcing social order by controlling the actions of group members (such as addressing persons in the neighborhood who are participating in deviant behaviors). These two factors may mutually influence one another, forming a cycle in which little social control contributes to neighborhood violence and vice versa (Sampson et al., 1997).

According to extensive research, there is a strong correlation between low socioeconomic Status (SES) and negative psychological traits, such as sadness and anxiety. It encompasses various factors such as income, education, occupation, and resource access, collectively influencing an individual's social standing and economic stability (Doorn, Suri & Gooptu, 2010). Low socioeconomic status is often associated with limited access to quality healthcare services, including preventive care, diagnostic facilities, and treatment options. This lack of access can lead to delayed or inadequate medical attention, resulting in poorer health outcomes and increased mortality rates for individuals in lower SES groups. Additionally, individuals with low SES may face financial constraints that prevent them from seeking timely medical assistance or affording necessary medications, further exacerbating health disparities. Socioeconomic Status (SES) is a multifaceted construct encompassing an individual's or a group's social and economic position. It includes factors such as income, education, occupation, and wealth, collectively determining one's access to resources and opportunities. In the context of health, socioeconomic Status plays a crucial role in shaping health outcomes and health inequalities. The socioeconomic Status of health inequality refers to the disparities in health outcomes and access to healthcare services among different socioeconomic groups. These inequalities are observed across various dimensions, including morbidity, mortality, disease prevalence, and healthcare utilization. Individuals from lower socioeconomic backgrounds experience worse health outcomes than those from higher socioeconomic backgrounds (Patalay & Fitzsimons, 2018).

People with lower socioeconomic status may face barriers to adopting and maintaining healthy behaviors due to factors such as limited time, financial constraints, and the availability of unhealthy environments. Socioeconomic Status strongly influences access to healthcare services. Individuals with higher socioeconomic status often have better health insurance coverage, more resources to afford healthcare expenses, and easier access to quality healthcare facilities Lu, Samuels & Wilson (2004). Individuals with higher socioeconomic status often have better access to healthcare resources, including quality medical care, preventive services, and health insurance coverage. In contrast, individuals with lower socioeconomic status may face barriers such as limited access to healthcare facilities, inadequate insurance coverage, or financial constraints, which can lead to delays in seeking care and receiving necessary treatments (Ensor & Cooper, 2004).

Educational attainment is a crucial determinant of socioeconomic status and health. Higher levels of education are associated with better health outcomes due to increased health literacy, better employment opportunities, higher income levels, and improved decision-making skills regarding healthcare utilization and healthy Berkman (2011). Efforts should focus on improving access to quality healthcare services, enhancing health education and literacy, promoting equitable employment opportunities, and creating healthier living environments for all residents.

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Methods

The research examines the correlation between socioeconomic status (SES) and disparities in health in District Okara, using a sample size of (N= 350) individuals. The study utilizes a cross-sectional research design and employs a stratified random sample approach the various socioeconomic strata within the area are adequately represented. Data on participants' demographic information, socioeconomic status indicators (such as income, education, and occupation), and health-related factors will be collected using a standardized questionnaire.

Table 01

Frequency and percentage distribution of the demographic variables

Variables	Frequency	Percentage
Age		
18-24	85	24.3
25-34	71	20.3
35-44	84	24.0
45-54	67	19.1
55 and Above	43	12.3
Gender		
Male	189	54.0
Female	161	46.0
Residence		
Urban	181	51.7
Rural	169	48.3
Educational Attainment:		
Less than high school	93	26.6
High School diploma or equivalent	109	31.1
Some colleges/associate degree	85	24.3
Bachelor’s degree	21	6.0
Master’s degree or higher	42	12.0
Marital Status		
Single	150	42.9
Married	116	33.1
Divorced	44	12.6
Widowed	40	11.4

Table 01 comprises the demographic factors of the respondents. Most individuals are 18-24 and 35-44, accounting for 24.3% and 24.0% of the total, respectively. The gender distribution is nearly equal, with 54.0% men and 46.0% females. 51.7% of the participants live in metropolitan regions, while 48.3% dwell in rural settings. The population's level of educational achievement varies, with those without a high school diploma or its equivalent making up the second-largest percentage (31.1%). 42.9% are single, 33.1% are married, 12.6% are divorced, and 11.4% are widowed.

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Table 02
One Way Analysis of Variance of health inequalities by socioeconomic status

	Sum of Squares	df	Mean Square	F	*p*
Between Groups	9024.752	2	4512.376	45.149	.000
Within Groups	34680.302	347	99.943		
Total	43705.054	349			

Table 03
Health Inequality HSK

		Subset for alpha = 0.05		
Socioeconomic Status	N	1	2	3
High	94	17.8085		
Medium	171		27.1579	
Low	85			31.4471
Sig.		1.000	1.000	1.000

Means for groups in homogeneous subsets are displayed.

Table 03 consisted of the results of the one way analysis of variance of health inequalities by socioeconomic status. The results showed that health inequality is significantly different by socioeconomic status of individuals. The post hoc Tukey HSD test further showed that individuals with high socioeconomic status have lower health inequalities. However, the individuals with lower socioeconomic status have high health inequalities. The individuals with medium socioeconomic status have medium health inequalities.

DISCUSSION

The discussion on the socioeconomic status of health inequalities highlights the significant impact of economic and social factors on individuals' health and well-being. Numerous studies and research have consistently shown that people from lower socioeconomic backgrounds tend to experience poorer health outcomes compared to those with higher socioeconomic status. The discussion revealed that health disparities exist across different socioeconomic groups. Ross & Mirowsky (2010) stated that People with higher incomes, better education, and access to resources generally have better health outcomes, while individuals with lower incomes and limited access to healthcare face higher rates of chronic illnesses, mortality, and disability. Ohlson (2020) explained that Socioeconomic status affects access to healthcare services. Individuals with higher incomes and private health insurance often have better access to medical care, preventive services, and early diagnosis, leading to improved health outcomes. On the other hand, people from lower socioeconomic backgrounds may encounter barriers in accessing healthcare due to financial constraints and lack of health insurance. The discussion also highlighted the role of social determinants of health in shaping health inequalities. Factors such as education, employment opportunities, housing, and community resources significantly influence health outcomes. Individuals with higher socioeconomic status generally have better access to these social determinants, leading to improved overall health. Socioeconomic status affects health behaviors and lifestyle choices. People with higher incomes and education levels tend to adopt healthier behaviors

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such as regular exercise, balanced nutrition, and avoiding harmful substances. In contrast, individuals with lower socioeconomic status may face barriers in adopting healthy behaviors due to economic constraints and environmental factors. The discussion emphasized the concept of cumulative disadvantage, where individuals from lower socioeconomic backgrounds experience a compounding effect of multiple disadvantages. These disadvantages can lead to a cycle of poor health outcomes, limited access to resources, and reduced opportunities for social mobility (Elman, Wray & Xi, 2014).

Conclusion

The evidence presented in this comprehensive review highlights the undeniable connection between socioeconomic status (SES) and health inequalities. Across various countries and societies, individuals with lower SES consistently face greater health disparities and reduced access to healthcare services, resulting in significant impacts on their well-being and overall population health. The study showed that individuals with high socioeconomic status have lower health inequalities. However, the individuals with lower socioeconomic status have high health inequalities. The individuals with medium socioeconomic status have medium health inequalities.

References

Bauer, J. M., Brand, T., & Zeeb, H. (2020). Pre-migration socioeconomic status and post-migration health satisfaction among Syrian refugees in Germany: a cross-sectional analysis. *PLoS medicine*, *17*(3), e1003093.

Berkman, N. D., Sheridan, S. L., Donahue, K. E., Halpern, D. J., & Crotty, K. (2011). Low health literacy and health outcomes: an updated systematic review. *Annals of internal medicine*, *155*(2), 97-107.

Buka, S. L., Stichick, T. L., Birdthistle, I., & Earls, F. J. (2001). Youth exposure to violence: Prevalence, risks, and consequences. *American journal of orthopsychiatry*, *71*(3), 298-310

Coleman, J. S. (1988). Social capital in the creation of human capital. *American journal of sociology*, *94*, S95-S120.

Crouch, J. L., Hanson, R. F., Saunders, B. E., Kilpatrick, D. G., & Resnick, H. S. (2000). Income, race/ethnicity, and exposure to violence in youth: Results from the national survey of adolescents. *Journal of community psychology*, *28*(6), 625-641.

Diez Roux, A. V., & Mair, C. (2010). Neighborhoods and health. *Annals of the New York academy of sciences*, *1186*(1), 125-145.

Elman, C., Wray, L. A., & Xi, J. (2014). Fundamental resource dis/advantages, youth health and adult educational outcomes. *Social Science Research*, *43*, 108-126.

Ensor, T., & Cooper, S. (2004). Overcoming barriers to health service access: influencing the demand side. *Health policy and planning*, *19*(2), 69-79.

Gallo, L. C., & Matthews, K. A. (2003). Understanding the association between socioeconomic status and physical health: do negative emotions play a role?. *Psychological bulletin*, *129*(1), 10.

Kirby, J. B., & Kaneda, T. (2005). Neighborhood socioeconomic disadvantage and access to health care. *Journal of health and social behavior*, *46*(1), 15-31.

Law, M., Wilson, K., Eyles, J., Elliott, S., Jerrett, M., Moffat, T., & Luginaah, I. (2005). Meeting health need, accessing health care: the role of neighbourhood. *Health & Place*, *11*(4), 367-377.

Labonte, R. (1999). Social capital and community development: Practitioner emptor. *Australian and New Zealand journal of public health*, *23*(4), 430-433.

Leeder, S., & Dominello, A. (1999). Social capital and its relevance to health and family policy. *Australian and New Zealand Journal of Public Health*, *23*(4), 424-429.

ISSN Online: 2709-7625
ISSN Print: 2709-7615

Litaker, D., Koroukian, S. M., & Love, T. E. (2005). Context and healthcare access: looking beyond the individual. *Medical care*, 531-540.

Lu, N., Samuels, M. E., & Wilson, R. (2004). Socioeconomic differences in health: how much do health behaviors and health insurance coverage account for?. *Journal of Health Care for the Poor and Underserved*, *15*(4), 618-630.

Mackenbach, J. P., Valverde, J. R., Artnik, B., Bopp, M., Brønnum-Hansen, H., Deboosere, P., ... & Nusselder, W. J. (2018). Trends in health inequalities in 27 European countries. *Proceedings of the National Academy of Sciences*, *115*(25), 6440-6445.

Ohlson, M. (2020). Effects of socioeconomic status and race on access to healthcare in the United States. *Perspectives*, *12*(1), 2.

Patalay, P., & Fitzsimons, E. (2018). Development and predictors of mental ill-health and wellbeing from childhood to adolescence. *Social psychiatry and psychiatric epidemiology*, *53*, 1311-1323.

Putnam, R. D. (2000). *Bowling alone: The collapse and revival of American community*. Simon and schuster.

Ross, C. E., & Mirowsky, J. (2010). Why education is the key to socioeconomic differentials in health. *Handbook of medical sociology*, *6*, 33-51.

Sampson, R. J., Raudenbush, S. W., & Earls, F. (1997). Neighborhoods and violent crime: A multilevel study of collective efficacy. *science*, *277*(5328), 918-924.

Srivastava, S., Chauhan, S., & Patel, R. (2021). Socio-economic inequalities in the prevalence of poor self-rated health among older adults in India from 2004 to 2014: a decomposition analysis. *Ageing International*, *46*(2), 182-199.

Van Doorn, R., Suri, V., & Gooptu, S. (2010). Do middle-income countries continue to have the ability to deal with the global financial crisis?. *World Bank Policy Research Working Paper*, (5381).

Wilkinson, R. G. (1997). Socioeconomic determinants of health: Health inequalities: relative or absolute material standards?. *Bmj*, *314*(7080), 591.

World Health Organization. (2003). *The world health report 2003: shaping the future*. World Health Organization.