

A review on socioeconomic aspects and their tangible effects on health and disease

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Abstract:

Although several methods have been employed to operationalize socioeconomic position, money, social class, and education are the most common ones. In this study, we also include occupational complexity and a SES-index as alternatives to income. Research has shown that social and economic factors influence the health disparities in the general population. The study's goals were to determine how socioeconomic factors affected nutritional status.

Key words: Economic factors, SES, Nutritional status

Introduction

Access to healthcare is unequal for different social classes in both developed and developing countries. Inequality in healthcare access exists in the United States for families from different socioeconomic backgrounds. In contrast to high-income families, low-income households, for example, have less access to healthcare, which results in greater rates of infant mortality. Evidence also implies that due of their racial origins, African Americans, Red Indians, and Hispanics have less access to healthcare than the majority-white population. Racial and socioeconomic characteristics are important in determining who has access to healthcare. Manual workers in France have poorer access to healthcare than their professional counterparts, according to a study by the French National Institute for Health and Social Security (INSERM) published in Le Monde on 26 April. The study compared

socioeconomic resources, as measured by income, occupation, and education, of manual and professional workers.[1]

Evidence shows that social factors, as opposed to medical care, play a significant role in determining health across a wide range of health indices, locations, and populations. This suggests that medical care is not the only factor that affects health and that its effects may be less widespread than previously believed. [2]

The relationship between socioeconomic status (SES) and health has been the subject of extensive investigation. In the 1960s, academics mainly held the view that, at least in industrialised countries, improvements in medical technology and economic expansion would reduce health disparities. Black found that during the 1980s, health disparities in Britain not only did not improve but but became much worse. Studies carried out in both the United States and Europe have supported this conclusion, which states that the health of the group with higher SES is unquestionably better than that of the group with lower SES. The mechanism underlying this phenomenon, however, has generated some debate. Academics have proposed the social causality theory and the health selection theory. According to the former, SES disparities are what ultimately drive health inequities. On the other hand, the latter suggests that persons with good health have a higher tendency to advance in society and have a higher SES. Despite these disagreements, there seems to be a growing consensus that people's lifestyles have a significant impact on how SES affects health. [3]

Since 1985, there has been a noticeable increase in the amount of research on the relationships between socioeconomic determinants and health. The theoretical framework now used to analyse health inequities was described by Nancy E. Adler and Joan M. Ostrove. Socioeconomic status was infrequently considered in health studies before the middle of the 1980s. At a meeting organised by the Kaiser Family

Foundation in 1987, eminent social scientists from the US and UK made a number of presentations that illustrated how socioeconomic difficulties had an impact that extended well beyond poverty. In actuality, a wide range of social and economic factors influence health. Health and socioeconomic status also have a gradient relationship, with health increasing as socioeconomic level increased. [4]

Data from two nationally representative Swedish surveys were pooled by Darin-Mattsson et al. in 2017, providing more than 20 years of follow-up. The association between the five SES variables and the three late-life health outcomes of mobility constraints, ADL difficulties, and psychological distress was compared using average marginal effects. Only slight variations in impact sizes existed across all socioeconomic status markers and late-life health. All indices of late-life health were most strongly correlated with income, and even after accounting for the other variables, these correlations remained statistically significant. In the fully adjusted models, social class, occupational complexity, income, and education all contributed between 0-3% (depending on the outcome) to the model fits.[5]

Hoffmann et al., (2018) used data from the Survey of Health Aging and Retirement in Europe (SHARE) third wave (SHARELIFE, version 5.0.0), in which people aged 50 and older were questioned about their current situation as well as how their SES and health have changed over time. The information is accurate for people over 50 and their spouses who reside in households in the relevant European nations. According to Börsch-Supan et al. (2013), SHARELIFE contains comprehensive information on developments and changes in health and SES. Personal home interviews along with computerised questionnaires were used to get the data. We restrict our research to 10 nations (Austria, Belgium, Denmark, France, Germany, Italy, Netherlands, Spain, Sweden, and Switzerland) since salary data for three SHARE nations (Poland, Czech

Republic), or it contained too many missing values, was not comparable across the life course (Greece). Additionally, we restrict the analysis to people who were 50 to 90 years old in 2008/2009 at the time of the interview ($n = 20,227$). Details of the participating nations are available online (<http://www.share-project.org/data-access-documentation/sample.html>), with the average response rate across nations hovering around 60% (and ranging from roughly 40% to 80%). In order to examine how SES and health interact, they selected a model-based approach to causal analysis employing life-long retrospective data. This is distinct from a design-based approach, like quasi-experiments, in that it emphasises causality within a model based on theoretical assumptions about how SES and health are related, whereas the design-based approach uses external variation, like in a natural experiment, needing fewer assumptions. A model-based approach has the advantage of having the ability to simultaneously model two linked processes (causation and selection), where the result of one process serves as a predictor of the other. SES and health are not strongly correlated in childhood, but the correlation increases with age; second, SES and health throughout the life course significantly depend on one's prior status; and third, the social causation path was as significant as the health selection path in the transition from childhood to working age, while the causation path was less significant in the transition from working age to old age. The fact that the autoregressive parameters for SES are significantly larger than those for health must also be taken into account when interpreting this finding. SES is less dependent on outside factors, such as health, if it is more influenced by its own past. [6]

The study, conducted at Imperial College London and published in *The Lancet*, found that having low socioeconomic status (SES) was linked to a 2.1-year reduction in life expectancy, having a nearly identical effect on health to smoking

or leading a sedentary lifestyle (2.4 years). Based on income, education, and occupation, SES assesses a person's or family's relative economic and social standing to others. Although it is previously established that these factors have an impact on health, no research have yet evaluated the effect of low SES with that of other significant risk factors. When predicting health outcomes, health policy frequently ignore risk variables including poverty and low educational attainment. [9]

How do social determinants affect health?

In our community, social factors play a crucial role in determining people's health. Social resource structures differ in their levels of inequality. Such disparities may represent the difference between a life of vigour and good health and one marred by chronic illness and ill health. They may also mean the difference between life and death. [7]

In order to alleviate health inequities through the social determinants of health, there are obstacles to be overcome. A vast and intricate area, social determinants of health equity. Numerous parties, both inside and outside the health industry, and all tiers of government are involved. Data on social determinants of health can also be challenging to gather and disseminate.

Although the body of research on the social determinants of health has grown over the past ten years, more needs to be done to spread successful good practises and strengthen the body of research on what actually works.

In order to address health inequities, three areas for important action were listed in the report of the Global Commission on Social Determinants of Health. These consist of:

- Improve the quality of daily life
- Tackle the inequitable distribution of power, money and resources
- Measure the issue, comprehend it, and evaluate the effect of potential solutions [8]

Lantz et al., revealed that the higher prevalence of health risk behaviours among people with lower levels of education and socioeconomic disadvantage is mostly to blame for the increased risk among the socioeconomically disadvantaged. [10]

Opportunities for people to improve their health might be impacted by socioeconomic level. Access to health care, wholesome food, safe homes and communities, opportunities for physical activity, and high-quality education is typically improved with increased money and wealth. As an illustration, Tennessee counties with higher median earnings typically have more primary care physicians who are actively practising for every resident.

Opportunities and resources of this nature can also affect how an individual behaves, including their use of preventive care, smoking, exercise, and food. For instance, Tennessee residents are more likely to smoke if their household income is lower.

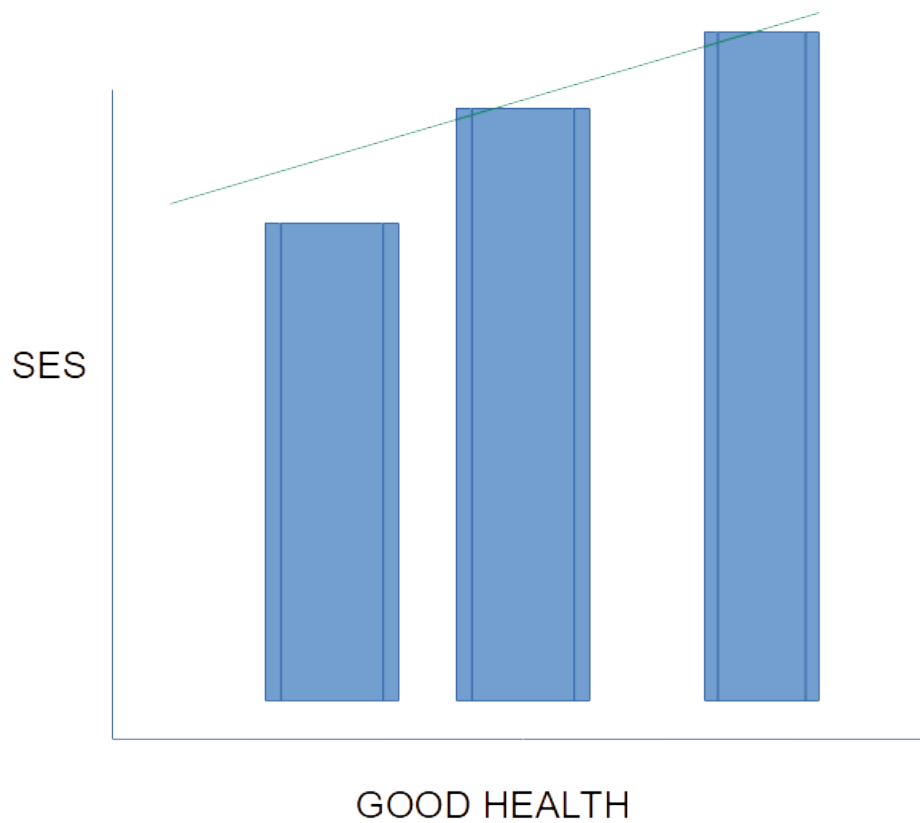
The lives of people are influenced by a variety of social and economic circumstances. These distinct measures are connected but distinct from one another. Income, wealth, and education are the most frequently cited factors. Higher wages are typically found among those with greater education. However, income among people with comparable levels of education frequently varies by age, race/ethnicity, and sex. For instance, the median wages of white and black Tennesseans with the same levels of schooling vary. [11]

Social influences on health are intertwined with the environment as a whole and are influenced by intricate interactions between social structures and economic systems. These institutions and processes have an effect on how power, money, and resources are distributed both locally and globally. The socioeconomic environment, or allocation of resources, determines how communities and individuals can obtain the

resources required to meet their fundamental human needs. Access to resources is greatly influenced by one's ability to get power, wealth, and knowledge. The socioeconomic status (SES) of a person is determined by how well off they are financially, socially, and professionally relative to the rest of their community. [12]

Socio-economic status (SES) in children's health

One of the most hotly contested topics in human rights is the effect of socioeconomic status (SES) on children. The adult world has an impact on the child's economic activities. According to various studies, children from middle- and high-SES households, in contrast to children from low-SES homes, have precise and rational policies because their parents respond to their children with logical justifications, and as a result, their children have more cultural capital. The youngster acquires sociolinguistic competences from this family. The economic standing of parents, particularly mothers, was linked to growth rate, nutritional quality, mental health, academic performance, IQ, mortality rate, and accidents. Implementing training programmes on healthy nutrition, accident prevention, dental health, and psychological therapies for families with low SES is therefore necessary. [13, 14, 15, 16]



Social inequalities in children's behaviour and health have been found in numerous longitudinal and cross-sectional research. They emphasise how a child's development is negatively impacted by having a low SES. Early illnesses or vulnerabilities may have a negative impact on a person's job and social position in the future, according to studies. Although the bulk of studies used parent-based SES measures, a number of studies highlighted the significance of child-based and neighborhood-level SES markers (such as perceived social position) (e.g. area deprivation). Study results highlight the advantages of initiatives intended to improve particular neighbourhood characteristics and people's psychosocial functioning in terms of interventions. The impact of interventions aimed at modifying the behaviours of children and families with low SES are minimal since the relationship between SES and health is

bidirectional and stable. Additional center-based and area-level interventions, as well as studies examining their impact, are required. [17]

Nutritional status and socioeconomic factors

To evaluate the nutritional status of primary schools in Lahore from February to August 2005, Muzzafae et al. conducted a cross-sectional survey of both state and private elementary schools going kids between the ages of 5 and 11 who come from various socioeconomic societal strata. To get the sample, a systematic random sampling technique was used. Considering the relationship between the nutritional status of children from lower socioeconomic class was poorer than that of children from higher socioeconomic class, according to the NHANES reference population. 41% of lower-class children had BMIs below the fifth percentile, compared to 19.28% of upper-class children. Malnutrition was more common in children of illiterate mothers (42.3%) than literate mothers (20%).

Socioeconomic factors and cardiovascular disease

Despite recent carnage declines, cardiovascular disease is now the leading cause of death in the United States. Many of the major risk factors for coronary artery disease appear to have been identified. Researchers are still learning about the various modifiable factors that may influence cardiovascular disease. Socioeconomic status could provide a new focus. The main indicators of SES were education, occupation, income, or a combination thereof. Education was the most common measure because (like occupation and income) it usually does not change after young adulthood, information on education is readily available, and poor health in adulthood is associated with. Because it is unlikely to affect educational attainment. However, other SES measurements have their place, and the most informative strategy involves multiple SES metrics. Various psychosocial characteristics (eg, certain aspects of

occupational status) can be important mediators of SES and illness. The hypothesis that high occupational exposures can impair health conditions has a rational basis and is supported by evidence from a limited number of studies. There is ample evidence of an association between socioeconomic factors and all-cause mortality. These results have been replicated repeatedly for over 80 years in socioeconomic level measures and in geographically diverse populations. Through 40 years of research, there was a consistent inverse correlation between cardiovascular disease, primarily coronary artery disease, and many indicators of his SES. Evidence for this association comes from prevalence, prospective, and retrospective cohort studies. Of particular relevance to the hypothesis that SES is a risk factor for cardiovascular disease is that the pattern of association between her SES and coronary artery disease in men has changed over the past 30 to 40 years and that SES is associated with it. It was a discovery by several researchers who said that It has been associated with reduced coronary mortality since the mid-1960s. However, the decline in coronary mortality in recent decades has not affected all social classes equally. There is evidence that cardiovascular mortality begins to slow in areas with the worst socio-environmental conditions¹⁹.

Conclusion:

People from low socioeconomic classes appear to have poorer health status due to poverty, low literacy rates, big families, and food insecurity. To enhance people's nutritional state, there must be improvements in the economy, politics, and society as well as changes for personal progress, mostly through educational opportunity.

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