

## Examining the Relationship Between Socioeconomic Status and Access to Quality Health and Social Care Services

<sup>1</sup>Dr Fahad Ali Khalid, <sup>2</sup>Dr Sajawal Mir, <sup>3</sup>Dr Mahnoor Bugti, <sup>4</sup>Mohib Ali, <sup>5</sup>Kashif Lodhi, <sup>6</sup>Dr Javed Akthar Hashmi

<sup>1</sup> Lecturer, Azad Jammu and Kashmir Medical College Muzaffarabad.

<sup>2</sup>Post graduate training, Aims Hospital Mzd

<sup>3</sup>Deputy director, Baqai institute of physical therapy and rehabilitation medicine

<sup>4</sup>PIMS

<sup>5</sup>Department of Agricultural, Food and Environmental Sciences. Università Politénica delle Marche Via Brece Bianche 10, 60131 Ancona (AN) Italy

<sup>6</sup>Assistant professor of community medicine Shahida islam medical and Dental college Lodhran

### ABSTRACT:

**Background:** Socioeconomic status (SES) has been consistently linked to disparities in health and social care access, impacting overall well-being. Understanding the specific barriers faced by different SES groups and the resulting outcomes is crucial for developing targeted interventions.

**Aim:** This study aimed to examine the relationship between socioeconomic status and access to quality health and social care services, identifying key barriers and their effects on health outcomes.

**Methods:** A comprehensive analysis was conducted on a study population of 90 participants from diverse socioeconomic backgrounds. Data were collected over a one-year period from January 2023 to January 2024. Quantitative data were obtained through structured questionnaires, while qualitative insights were gathered via in-depth interviews. Statistical analysis was employed to identify significant correlations between SES and access to services, and thematic analysis was used to explore qualitative data.

**Results:** The study found that individuals from lower socioeconomic groups faced significant barriers in accessing quality health and social care services. These barriers included financial constraints, lack of insurance, limited availability of services, and insufficient health literacy. Consequently, these individuals experienced poorer health outcomes compared to those from higher socioeconomic backgrounds. The analysis highlighted that improved access to information and financial support could mitigate some of these disparities.

**Conclusion:** Socioeconomic status was a critical determinant of access to quality health and social care services. The identified barriers contributed to substantial inequalities in health outcomes. Addressing these barriers through policy changes and targeted interventions is essential to ensure equitable access to care for all socioeconomic groups.

**Keywords:** Socioeconomic status, health disparities, access to care, health outcomes, social care services, barriers to healthcare.

### INTRODUCTION:

The investigation into the relationship between socioeconomic status (SES) and access to quality health and social care services has long been a critical area of study within public health and social policy.

Historically, disparities in access to healthcare and social services were observed to correlate strongly with socioeconomic factors [1]. These disparities manifested in various forms, including differences in service availability, quality of care received, and overall health outcomes. This comprehensive analysis sought to elucidate the multifaceted barriers that individuals from different socioeconomic backgrounds encountered and to assess the resultant health and social outcomes [2].

Socioeconomic status, typically determined by a combination of income, education, occupation, and sometimes wealth, was consistently found to be a determinant of health and social care access. Lower SES groups often faced a myriad of barriers that impeded their ability to obtain quality care [3]. These barriers included financial constraints, limited availability of services in impoverished areas, lack of transportation, and insufficient health literacy. Additionally, systemic issues such as discrimination, policy inadequacies, and institutional biases further compounded these challenges [4]. The interplay of these factors created a complex landscape that disadvantaged lower SES populations.

Financial constraints were arguably the most significant barrier for lower SES individuals. The high cost of healthcare services, including insurance premiums, copayments, and out-of-pocket expenses for medications and treatments, often rendered quality care inaccessible [5]. For many, the choice between healthcare and other essential needs such as housing and food was a daily reality. This financial strain was exacerbated by the limited availability of free or low-cost health services, particularly in rural and underserved urban areas [6]. Consequently, many individuals from lower SES backgrounds resorted to delaying or forgoing necessary medical care, which invariably led to poorer health outcomes.

Geographic disparities also played a crucial role in access to health and social care services. Rural and low-income urban areas frequently lacked adequate healthcare facilities and providers [7]. These regions suffered from a shortage of healthcare professionals, which resulted in longer wait times and reduced availability of specialized care [8]. Furthermore, transportation barriers hindered access to distant healthcare facilities, thereby limiting the options available to those in need. Public transportation in many low-income areas was either unreliable or nonexistent, posing an additional obstacle for individuals requiring consistent medical attention.

Health literacy was another significant barrier that disproportionately affected lower SES groups [9]. Health literacy encompassed the ability to understand and effectively use health information to make informed decisions about one's health. Lower educational attainment, prevalent in lower SES populations, often correlated with lower health literacy levels [10]. This gap in understanding made it challenging for individuals to navigate the healthcare system, adhere to medical advice, and engage in preventive health behaviors. Consequently, lower health literacy contributed to the exacerbation of health disparities among socioeconomic groups [11].

Systemic and institutional biases further entrenched disparities in access to quality care. Discriminatory practices within healthcare settings, whether based on race, ethnicity, or socioeconomic status, often resulted in suboptimal treatment and negative patient experiences [12]. Additionally, policies that failed to address the unique needs of lower SES populations perpetuated inequities. For instance, inadequate funding for public health programs and social services disproportionately affected these communities, leaving them with fewer resources and support [13].

The outcomes of these barriers were stark. Lower SES groups consistently exhibited worse health outcomes compared to their higher SES counterparts. These outcomes included higher rates of chronic diseases, lower life expectancy, and greater prevalence of mental health issues [14]. Moreover, the social ramifications were equally profound, encompassing reduced quality of life, increased stress, and broader social inequities.

In summary, this comprehensive analysis underscored the intricate relationship between socioeconomic status and access to quality health and social care services. By examining the barriers faced and the consequent outcomes, the study aimed to inform policies and interventions that could mitigate these disparities and promote equitable access to care for all socioeconomic groups [15].

## **METHODOLOGY:**

### **Study Design:**

This study employed a mixed-methods approach to examine the relationship between socioeconomic status (SES) and access to quality health and social care services. The design integrated quantitative and qualitative data collection and analysis methods to provide a comprehensive understanding of the barriers faced and outcomes experienced by individuals from different socioeconomic backgrounds. The study was conducted over a period of 12 months, from January 2023 to January 2024.

### **Study Population:**

The study population consisted of 90 participants selected from various socioeconomic backgrounds to ensure diversity and representativeness. Participants were recruited from urban, suburban, and rural areas to capture a wide range of experiences and challenges related to access to health and social care services. Inclusion criteria included individuals aged 18 and above, who had utilized health or social care services at least once in the past year. Exclusion criteria included individuals who were unable to provide informed consent or who had severe cognitive impairments that hindered their ability to participate in interviews or complete surveys.

### **Sampling Method:**

A stratified random sampling method was employed to ensure representation across different socioeconomic strata. Participants were categorized into low, middle, and high SES based on income, education level, and occupation. Each stratum was proportionately represented in the final sample to facilitate comparative analysis. Recruitment was conducted through community centers, healthcare facilities, and social service organizations, with efforts made to reach underrepresented groups.

### **Data Collection:**

Data collection was carried out in two phases: quantitative and qualitative.

#### **Quantitative Phase:**

**Survey Administration:** A structured survey was administered to all participants. The survey included questions on demographic information, SES indicators, health and social care service utilization, perceived barriers to accessing services, and health outcomes. Standardized instruments such as the Health Care Access Survey and the Social Care Barriers Scale were used to ensure reliability and validity.

**Health and Social Care Records:** Participants consented to the review of their health and social care records, which provided additional data on service utilization, types of services accessed, frequency of visits, and documented health outcomes.

#### **Qualitative Phase:**

**In-depth Interviews:** Semi-structured interviews were conducted with a subset of 30 participants (10 from each SES category) to gain deeper insights into their experiences and perceptions. The interview guide focused on exploring personal narratives about barriers to accessing care, the quality of services received, and the impact of SES on health and social outcomes.

**Focus Groups:** Two focus group discussions were held with healthcare and social service providers to understand systemic barriers and facilitators to providing quality care across different SES groups.

#### **Data Analysis:**

Quantitative data were analyzed using descriptive and inferential statistics. Descriptive statistics summarized the demographic characteristics, SES distribution, service utilization patterns, and perceived barriers. Inferential statistics, including chi-square tests and logistic regression analyses, were used to examine the relationships between SES and access to services, as well as the impact of SES on health outcomes.

Qualitative data from interviews and focus groups were transcribed verbatim and analyzed using thematic analysis. Themes were identified through an iterative process of coding and categorization, which involved multiple readings of the transcripts and discussions among the research team to ensure accuracy and consistency.

#### **Ethical Considerations:**

The study protocol was reviewed and approved by the Institutional Review Board (IRB) of the sponsoring institution. All participants provided informed consent prior to participation. Confidentiality and anonymity were maintained by assigning unique identifiers to participants and securely storing all data. Participants were informed of their right to withdraw from the study at any time without any consequences.

#### **RESULTS:**

The participants were divided into three groups based on their SES: high, middle, and low. Two tables were created to summarize the findings. Table 1 presents the demographic distribution and SES categorization of the study population. Table 2 illustrates the relationship between SES and access to health and social care services, focusing on the barriers encountered and the outcomes achieved.

**Table 1: Demographic Distribution and SES Categorization:**

SES Category	Number of Participants	Mean Age (years)	Gender Distribution (M/F)	Employment Status (Employed/Unemployed)
High	30	45.6	14/16	28/2
Middle	30	42.3	15/15	22/8
Low	30	39.8	13/17	10/20
Total	90	-	42/48	60/30

Table 1 provides an overview of the study population divided into three socioeconomic status (SES) categories: high, middle, and low. Each group consisted of 30 participants, making the total study population 90. The mean age for participants in the high SES group was 45.6 years, the middle SES group was 42.3 years, and the low SES group was 39.8 years. Gender distribution showed a slight predominance

of females across all groups, with 16 females in the high SES group, 15 in the middle SES group, and 17 in the low SES group. Employment status was also recorded, revealing that the majority of participants in the high SES group were employed (28 out of 30), while employment was lower in the middle (22 out of 30) and particularly low in the low SES group (10 out of 30).

**Table 2: Access to Health and Social Care Services: Barriers and Outcomes:**

SES Category	Access to Health Services (%)	Access to Social Care Services (%)	Major Barriers Identified	Positive Health Outcomes (%)	Positive Social Care Outcomes (%)
High	95	90	Minimal barriers	85	80
Middle	70	65	Moderate barriers	60	55
Low	40	35	Significant barriers	30	25

Table 2 summarizes the participants' access to health and social care services, the barriers they encountered, and the outcomes they achieved. Access to health services was highest among the high SES group, with 95% reporting adequate access, compared to 70% in the middle SES group and 40% in the low SES group. Similarly, access to social care services was highest among the high SES group (90%), followed by the middle SES group (65%) and the low SES group (35%).

Participants identified various barriers to accessing services. Those in the high SES group reported minimal barriers, primarily related to service availability and convenience. In contrast, participants in the middle SES group faced moderate barriers, such as financial constraints and limited service availability. The low SES group encountered significant barriers, including financial hardship, lack of insurance, transportation issues, and limited awareness of available services.

The outcomes reflected the disparities in access and barriers. Positive health outcomes, defined as improved physical and mental health status, were reported by 85% of participants in the high SES group, 60% in the middle SES group, and 30% in the low SES group. Similarly, positive social care outcomes, measured by improvements in social well-being and support networks, were highest in the high SES group (80%), followed by the middle SES group (55%) and the low SES group (25%).

#### **DISCUSSION:**

The relationship between socioeconomic status (SES) and access to quality health and social care services had long been a subject of comprehensive analysis, revealing significant disparities influenced by various barriers and outcomes [16]. Historically, individuals from lower socioeconomic backgrounds encountered substantial obstacles that impeded their ability to obtain high-quality healthcare and social services. These barriers ranged from financial constraints and limited health literacy to geographic inaccessibility and systemic biases, all of which collectively contributed to poorer health outcomes.

Financial barriers played a pivotal role in shaping access to healthcare [17]. Lower-income individuals often lacked sufficient health insurance coverage, leading to increased out-of-pocket expenses for medical

services and medications. This financial strain deterred many from seeking necessary medical care, resulting in delayed diagnoses and untreated conditions [18]. The inability to afford preventive care and regular check-ups further exacerbated health issues, creating a cycle of deteriorating health among disadvantaged populations.

Health literacy emerged as another critical factor influencing access to quality care. Individuals with lower SES frequently had limited education, which correlated with reduced understanding of medical information and health practices [19]. This lack of knowledge hindered their ability to make informed decisions regarding their health, adhere to prescribed treatments, and navigate the complex healthcare system. Consequently, these individuals often experienced poorer health outcomes and higher rates of chronic diseases [20].

Geographic inaccessibility compounded the challenges faced by lower-income populations. Rural and underserved urban areas, where many low-SES individuals resided, often had fewer healthcare facilities and providers [21]. This scarcity of resources meant longer travel distances and wait times for medical appointments, discouraging individuals from seeking timely care. Additionally, transportation costs and difficulties further limited their access to necessary services, leading to unmet medical needs and worsening health conditions.

Systemic biases within the healthcare system also played a significant role in perpetuating disparities. Implicit biases among healthcare providers, influenced by patients' socioeconomic status, affected the quality of care delivered [22]. Studies had shown that lower-income individuals were more likely to receive substandard care, face discrimination, and experience less effective communication with their providers. This inequitable treatment undermined their trust in the healthcare system and discouraged them from seeking care, further perpetuating health disparities.

The outcomes of these barriers were evident in various health indicators. Lower socioeconomic status was consistently associated with higher rates of morbidity and mortality [23]. Individuals from disadvantaged backgrounds experienced increased prevalence of chronic diseases such as diabetes, hypertension, and cardiovascular conditions. Moreover, they faced higher rates of mental health issues, including depression and anxiety, often exacerbated by the stressors associated with financial instability and social inequality.

Efforts to address these disparities had included policy interventions aimed at improving access to healthcare for low-SES populations [24]. Expansions in health insurance coverage, such as through Medicaid and the Affordable Care Act, sought to reduce financial barriers. Community health programs and mobile clinics aimed to bring services to underserved areas, addressing geographic inaccessibility. Additionally, initiatives focused on enhancing health literacy through education and outreach programs had been implemented to empower individuals to take charge of their health [25].

Despite these efforts, significant challenges remained in achieving equitable access to quality health and social care services. Comprehensive and sustained approaches were necessary to dismantle the multifaceted barriers faced by lower-income populations. This included addressing the root causes of socioeconomic disparities, such as poverty and educational inequalities, and fostering a healthcare system that prioritized equity and inclusivity.

The relationship between socioeconomic status and access to quality health and social care services revealed profound inequities driven by financial, educational, geographic, and systemic barriers. These disparities resulted in poorer health outcomes for disadvantaged populations, underscoring the urgent

need for continued efforts to promote equitable healthcare access and improve the overall well-being of lower-SES individuals.

### **CONCLUSION:**

The comprehensive analysis revealed that socioeconomic status significantly impacted access to quality health and social care services. Lower socioeconomic groups faced numerous barriers, including financial constraints, limited availability of services, and lack of awareness. These obstacles often resulted in poorer health outcomes and reduced overall well-being. The study underscored the necessity for policy interventions to address these disparities and promote equitable access to care. By highlighting the link between socioeconomic status and healthcare access, the analysis contributed valuable insights for developing strategies to enhance service delivery and improve health outcomes for disadvantaged populations.

### **REFERENCES:**

1. McMaughan DJ, Oloruntoba O, Smith ML. Socioeconomic status and access to healthcare: interrelated drivers for healthy aging. *Frontiers in public health*. 2020 Jun 18;8:512143.
2. Magesh S, John D, Li WT, Li Y, Mattingly-App A, Jain S, Chang EY, Ongkeko WM. Disparities in COVID-19 outcomes by race, ethnicity, and socioeconomic status: a systematic review and meta-analysis. *JAMA network open*. 2021 Nov 1;4(11):e2134147-.
3. Nidoi J, Muttamba W, Walusimbi S, Imoko JF, Lochoro P, Ichtho J, Mugenyi L, Sekibira R, Turyahabwe S, Byaruhanga R, Putoto G. Impact of socio-economic factors on Tuberculosis treatment outcomes in north-eastern Uganda: a mixed methods study. *BMC Public Health*. 2021 Dec;21:1-6.
4. Heponiemi T, Jormanainen V, Leemann L, Manderbacka K, Aalto AM, Hyppönen H. Digital divide in perceived benefits of online health care and social welfare services: national cross-sectional survey study. *Journal of medical Internet research*. 2020 Jul 7;22(7):e17616.
5. Ocloo J, Garfield S, Franklin BD, Dawson S. Exploring the theory, barriers and enablers for patient and public involvement across health, social care and patient safety: a systematic review of reviews. *Health research policy and systems*. 2021 Dec;19:1-21.
6. Dadras O, Dadras F, Taghizade Z, Seyedalinaghi S, Ono-Kihara M, Kihara M, Nakayama T. Barriers and associated factors for adequate antenatal care among Afghan women in Iran; findings from a community-based survey. *BMC pregnancy and childbirth*. 2020 Dec;20:1-1.
7. Wolfe MK, McDonald NC, Holmes GM. Transportation barriers to health care in the United States: findings from the national health interview survey, 1997–2017. *American journal of public health*. 2020 Jun;110(6):815-22.
8. Hill-Briggs F, Adler NE, Berkowitz SA, Chin MH, Gary-Webb TL, Navas-Acien A, Thornton PL, Haire-Joshu D. Social determinants of health and diabetes: a scientific review. *Diabetes care*. 2021 Jan;44(1):258.
9. Albon D, Van Citters AD, Ong T, Dieni O, Dowd C, Willis A, Sabadosa KA, Scalia P, Reno K, Oates GR, Schechter MS. Telehealth use in cystic fibrosis during COVID-19: association with race, ethnicity, and socioeconomic factors. *Journal of Cystic Fibrosis*. 2021 Dec 1;20:49-54.

10. Sui Y, Ahuru RR, Huang K, Anser MK, Osabohien R. Household socioeconomic status and antenatal care utilization among women in the reproductive-age. *Frontiers in public health*. 2021 Sep 13;9:724337.
11. Kim S, Kim S. Analysis of the impact of health beliefs and resource factors on preventive behaviors against the COVID-19 pandemic. *International journal of environmental research and public health*. 2020 Nov;17(22):8666.
12. Coombs NC, Meriwether WE, Caringi J, Newcomer SR. Barriers to healthcare access among US adults with mental health challenges: a population-based study. *SSM-population health*. 2021 Sep 1;15:100847.
13. Jilani MH, Javed Z, Yahya T, Valero-Elizondo J, Khan SU, Kash B, Blankstein R, Virani SS, Blaha MJ, Dubey P, Hyder AA. Social determinants of health and cardiovascular disease: current state and future directions towards healthcare equity. *Current atherosclerosis reports*. 2021 Sep;23:1-1.
14. Green H, Fernandez R, MacPhail C. The social determinants of health and health outcomes among adults during the COVID-19 pandemic: A systematic review. *Public Health Nursing*. 2021 Nov;38(6):942-52.
15. Vilar-Compte M, Burrola-Méndez S, Lozano-Marrufo A, Ferré-Eguiluz I, Flores D, Gaitán-Rossi P, Teruel G, Pérez-Escamilla R. Urban poverty and nutrition challenges associated with accessibility to a healthy diet: a global systematic literature review. *International Journal for Equity in Health*. 2021 Dec;20:1-9.
16. Javed Z, Haisum Maqsood M, Yahya T, Amin Z, Acquah I, Valero-Elizondo J, Andrieni J, Dubey P, Jackson RK, Daffin MA, Cainzos-Achirica M. Race, racism, and cardiovascular health: applying a social determinants of health framework to racial/ethnic disparities in cardiovascular disease. *Circulation: Cardiovascular Quality and Outcomes*. 2022 Jan;15(1):e007917.
17. Reddick CG, Enriquez R, Harris RJ, Sharma B. Determinants of broadband access and affordability: An analysis of a community survey on the digital divide. *Cities*. 2020 Nov 1;106:102904.
18. Van Wilder L, Pype P, Mertens F, Rammant E, Clays E, Devleeschauwer B, Boeckxstaens P, De Smedt D. Living with a chronic disease: insights from patients with a low socioeconomic status. *BMC family practice*. 2021 Dec;22:1-1.
19. Eberly LA, Yang L, Eneanya ND, Essien U, Julien H, Nathan AS, Khatana SA, Dayoub EJ, Fanaroff AC, Giri J, Groeneveld PW. Association of race/ethnicity, gender, and socioeconomic status with sodium-glucose cotransporter 2 inhibitor use among patients with diabetes in the US. *JAMA network open*. 2021 Apr 1;4(4):e216139-.
20. Vazquez CE, Cubbin C. Socioeconomic status and childhood obesity: a review of literature from the past decade to inform intervention research. *Current obesity reports*. 2020 Dec;9:562-70.
21. Rawal LB, Smith BJ, Quach H, Renzaho AM. Physical activity among adults with low socioeconomic status living in industrialized countries: A meta-ethnographic approach to understanding socioecological complexities. *Journal of environmental and public health*. 2020;2020(1):4283027.



22. Renner J, Blaszyk W, Täuber L, Dekker A, Briken P, Nieder TO. Barriers to accessing health care in rural regions by transgender, non-binary, and gender diverse people: a case-based scoping review. *Frontiers in endocrinology*. 2021 Nov 18;12:717821.
23. Adugna MB, Nabbouh F, Shehata S, Ghahari S. Barriers and facilitators to healthcare access for children with disabilities in low and middle income sub-Saharan African countries: a scoping review. *BMC health services research*. 2020 Dec;20:1-1.
24. Klein M, Sosu EM, Dare S. Mapping inequalities in school attendance: The relationship between dimensions of socioeconomic status and forms of school absence. *Children and Youth Services Review*. 2020 Nov 1;118:105432.
25. Min KD, Yi SJ, Kim HC, Leem JH, Kwon HJ, Hong S, Kim KS, Kim SY. Association between exposure to traffic-related air pollution and pediatric allergic diseases based on modeled air pollution concentrations and traffic measures in Seoul, Korea: a comparative analysis. *Environmental Health*. 2020 Dec;19:1-2.
- 26.