

Complexity of the Socioeconomic Status and its Disparity as a Determinant of Health

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The socioeconomic (SE) status is considered to be one of the most important health risk factors nowadays. A simple search showed that only in 2011, more than 1100 articles were cited in Pubmed about the relationship of health and SE status. However, there are many inquiries about this association. The SE status is a complex and multidimensional issue, and there is no gold standard method to measure it.^[1] More importantly, the impact of SE status on different aspects of health is not clear.^[2]

The SE status is a broad and multidimensional term.^[3] The first component of the SE status covers the social class of subjects; which means, it considers if the person has an acceptable social position. Usually, education is measured as a proxy of a social class of people; unfortunately, the other aspects of the social class of people are much more complex to be approached.^[1] However, the educational level of people is measured with different scales, from a very simple binary scale (literate / illiterate) up to a numeric scale (year of education).

The second component of the SE status speaks about the affluence and proceeds of subjects. Nevertheless, this component also has no clear definition. The income, expenditure, or the possessions of an individual or a household might be measured in this regard. However, informational bias and a high rate of non-responses are the two main concerns.^[1]

Although these two components of the SE status

have a significant correlation, their association is not strong enough to be replaced.^[3-5] Therefore, as a general role, it is recommended to measure both dimensions simultaneously. In order to assess the impact of the SE status on health, usually a composition scale is created, to combine the different SE components, either by creating a very simple additive scale, or by formulating a complex weighted scale using a principal component analysis.

The above-mentioned scales measure the SE status at an individual level. However, there is a great deal of literature, which has assessed the association of SE and health at the community level, using group SE status indices. For example, the literacy rate and / or gross domestic products (GDP) of countries are used commonly at the global level. The same approach is used to assess the SE status of inhabitants in provinces, cities, and even localities. Although this approach is easy to implement, obviously an ecological fallacy might distort the whole conclusion.^[1,6]

By now, briefly, the difficulties in measuring the SE status have been presented. However, the link between SE status and health is much more complex.^[3] First of all, the association between these two is bilateral. It means that a low SE status may increase the risk of many diseases. Reversely, health troubles at individual, family, or community levels may decrease the SE status of people. On top of that, usually this association is evaluated in cross-sectional studies. As the SE status may

be change in time,^[1] the temporal gap between a low SE status and the risk of diseases cannot be addressed easily in cross-sectional studies.

Another issue is the pathways among components of the SE status and different aspects of health. Obviously, the SE components are linked to health via different routes and intermediate factors. For instance, poverty, in the long term, may deteriorate the genetic pool of a population, increase risky behaviors, decrease access to health care (both preventive and curative) services, and change the lifestyle of people.^[5,7] On account of very multifarious links among these parts, the impact of SE on health is not exactly comparable in different communities. For example, a low SE status mainly increases the cardiovascular risk of people in the US, while in Europe, it has a stronger association with cancer.^[6]

In order to evaluate the association between SE status and health, at any individual or community level, we have to explore the disparities. In other words, differences in the health status of people within different SE categories illustrate the impact of SE status on health.^[4,8,9] As components of the SE status have diverse variations in a community, there is a big question; how can we quantify disparities? For example, an observed association between SE status and health may be inferred as a moderate association with the economic component that usually has a wider variation in a community, or a strong association with the social component, which usually has less variation.

Finally, we have to take into consideration the fact that risk factors and risk markers are different.^[10] Poverty on its own, is mainly a risk marker and not a real risk factor for many diseases. As, poor people do not have access to many facilities, their cancers might be detected in more advance stages; therefore, poverty on its own is a marker for a higher mortality rate from cancer and not the main cause for that.

On the basis of the above-mentioned

explanation, it seems that speaking about the association between SE status and health is not an easy topic and needs to be addressed very deeply in longitudinal studies, mainly at individual levels. However, because of variations in the SE components in different communities and even differences in their definitions and concepts, the studies have to be adapted accordingly.

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