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Sustainable Public Healthcare Access: The Role of Socioeconomic Status in Achieving Equity And Resilience

Dr. Syama U S[1*], Ms. Preethi S.J.G[2]

[1*]Assistant Professor, Department of Economics, School of Commerce, Accounting and Finance, Kristu Jayanti Deemed to be University, Bangalore, India E-mail: syama.us@kristujayanti.com

[2]Assistant Professor, Department of Economics, School of Commerce, Accounting and Finance, Kristu Jayanti Deemed to be University, Bangalore, India E-mail: preethi.s@kristujayanti.com

Abstract

Equitable and resilient access to public healthcare is a fundamental component of the attainment of equity and resilience in healthcare systems, especially where socioeconomic inequalities exist. This research investigates the link between socioeconomic status (SES) and public healthcare access, focusing on the significance of sustainability in addressing systemic disparities. Adopting a mixed-method research design, the study integrates quantitative evidence from surveys and medical records with qualitative evidence from case studies and interviews. The results indicate that financial limitations, geographical distance, and poor health infrastructure disproportionately impact lower SES populations, widening healthcare disparities. Long-term policy interventions like universal health coverage, community-based health programs, and strategic resource planning are needed to close the accessibility gap. The research promotes long-term investment in healthcare infrastructure, education, and preventive care to build system resilience and provide equitable access to healthcare for all populations.

Keywords: *Sustainable healthcare, socioeconomic status, healthcare access, equity, resilience, public health policy, healthcare infrastructure, universal health coverage*

JEL Classification Codes: CO1, C35, I15

INTRODUCTION

Healthcare sustainability refers to the potential of a healthcare system to deliver high-quality, accessible, and affordable healthcare in the long term without compromising resources for future generations. A sustainable healthcare system not just meets present health needs but also ensures that care services are sustainable and resistant against socioeconomic crises, environmental fluctuations, and changing risk factors for diseases. This research incorporates the principle of sustainability through an assessment of how public healthcare systems can be designed to minimize disparities in access to healthcare while ensuring long-term sustainability. Through targeting socioeconomic determinants, sustainable health policies seek to establish an inclusive system that will enable equitable access for everyone, especially marginalized and poor populations.

Socioeconomic Status (SES) is one key factor that influences a person's overall health. In addition, it has an impact on the services available to the person, as well as the quality of care a person is receiving. Nonetheless, for a public health measure to be successful, it is crucial to understand the determinants which contribute to the differential health status across communities of different socioeconomic groups. This study employs a multidisciplinary approach comprising public health, sociology and economics to explore the variables involved in healthcare accessibility and its relationship with SES. The aim is to present a comprehensive context which stresses the need to address the social inequalities so that the egalitarian principle underpinning the health system is realized through an analysis of traditions, differential access, and health practices associated with different socioeconomic status. Health inequities persist globally due to complex interactions between social determinants and healthcare systems (World Health Organization [WHO], 2010), making socioeconomic status a critical factor in healthcare access.

Studies have repeatedly shown that less-advantaged populations across different socioeconomic strata

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still encounter considerable barriers to seeking care, thereby exacerbating health inequities in themselves (Pampel et al., 2010). For achieving universal healthcare as developed nations globally are trying to make a move toward, formulating equitable policies necessitates knowledge of the impact that SES imposes on access to health. The COVID-19 pandemic has further exposed and amplified such inequalities in the recent past and thus made the issue even more pressing. For instance, Little et al. (2021) found that low-income populations in the United States are experiencing disproportionately higher rates of COVID-19 infection and mortality due to limited healthcare access, crowded living conditions, and pre-existing health conditions. Similarly, in developing countries, in which state- financed healthcare provisions are seldom well equipped, SES becomes the much stronger determinant of the outcomes of healthcare (Peters et al., 2008).

It has also highlighted the multi-dimensional nature of SES, which entangles with other social determinants of health such as race, gender, and age in synergizing complex barriers to healthcare access. The author further noted how D. Kumar et al. (2022) recently mentioned how marginalized communities, especially those from lower socioeconomic backgrounds, could face cumulative disadvantages that limit access to timely and adequate healthcare thus producing poorer health outcomes over time.

Various policy initiatives, including public health programs, have been undertaken to reduce the disparities; however, mixed results are observed. Barnes et al. (2023) express that even though healthcare reforms improved access for some people in certain regions, the causes of SES-related health inequities were not adequately addressed. This calls for a more holistic and interdisciplinary approach that incorporates such insights from public health, economics, sociology, and urban planning toward systemic barriers in the case of lower-income groups (Becker and Newsom,2003).

Using a mixed-method approach, the study combines quantitative information from beneficiary surveys, key informant interviews by using structured questionnaire and medical records with qualitative insights from case studies and interviews. In order to guarantee the sample's representativeness, it was collected using the stratified random sampling approach, and the sample size was determined using appropriate formula.385 samples have been collected and analysed. The level of

income, educational achievement, and type of occupation, social capital, and health literacy are important determinants. Document reviews, focus groups, and semi-structured interviews have all been used to gather qualitative data. A systematic questionnaire was used to gather quantitative data, which was then analyzed using the econometric method of logistic regression and the statistical package SPSS. In this respect, Using such a cross cut approach enables not only an understanding of the challenges faced by the lower SES groups in relation to healthcare access but rather pinpoint specific areas that require addressing in efforts to promote health equality. The main objectives if this research is analyze the role of interdisciplinary factors to establish the relationship between access to public healthcare services and the characteristics of social economic status (SES).

The first section of the research includes the background of the study followed by reviewing the existing literatures. After reviewing the literature the analysis has been carried out based on the hypothesis which are to be proved with the help of stated methodology.

LITERATURE REVIEW

Healthcare sustainability is the capacity of a health system to deliver high-quality, accessible, and affordable care in the long term without sacrificing resources for future generations. A sustainable health system not only meets present public health demands but also maintains healthcare services equitable and resilient against socioeconomic pressures, environmental shifts, and changing health threats. This research incorporates the theme of sustainability by looking at how public healthcare systems can be designed to minimize differences in access to healthcare while preserving long-term sustainability. Through a socioeconomic determinants lens, sustainable healthcare policies target establishing an inclusive environment that

fosters equitable access to all, most importantly marginalized and low-income groups.

Public healthcare provision is one of the most visibly important problems worldwide; one that has SES as a determining factor when it comes to quality and ease of accessibility that patients have available. It was over the last two decades that a huge collection of studies researched the very complex relationship between SES and healthcare, highlighting fundamentally economic, social, and policy- related aspects that influence health outcomes.

A number of studies show that income disparities play an important role in deciding healthcare access. Marmot (2005) first introduced the concept of social determinants of health and proved that people from the lower SES groups face a consistent disadvantage in accessing health services and health care results. This concept is supported by recent studies also, such as Braveman et al. (2011) which reaffirmed the relationship between income inequality and limited access to healthcare services and stated that these are continued inequalities in different geographic areas.

Education is significant for developing access to health care according to Cutler and Lleras-Muney (2006).Such people tend to spend a lot of time performing the preventive health behaviors as well as being offered the very best kind of health services. Education increases health literacy through better provision of people to understand more complex services properly. Phelan et al. (2010) expanded upon this analysis by proposing the "Fundamental Cause Theory," which posits that socioeconomic determinants, such as education, act as essential obstacles to obtaining healthcare services. Their research underscores that despite advancements in healthcare technologies, individuals in lower socioeconomic status (SES) categories persistently encounter challenges in accessing these innovations because of limitations in resources.

Systemic inefficiencies and poverty further compound the link between SES and healthcare access in developing countries. Victora et al. (2016) analyzed maternal and child health services across low- income countries, finding that SES plays a determining role in access to core services despite attempts at universal healthcare policies. These issues are usually exacerbated by government policies, according to an analysis by Wagstaff on health inequalities in low- and middle-income countries published in 2002 (Poverty and Health Sector Inequalities, 2002).

A number of studies have examined the effects of sustainable healthcare models on long-term public health outcomes, resource utilization, and access equity (Fair Society Healthy Lives (the Marmot Review) - Institute of Health Equity, n.d.) study emphasizes how sustainable healthcare systems need to incorporate social determinants of health in order to act upon disparities and provide long-term resilience (Bambra et al., 2010). In the same line, Wagstaff and Van Doorslaer (2000) underscore that universal coverage of healthcare, when prioritized with sustainability, can bring substantial reductions in healthcare inequities and enhance population health over the long term. The WHO's foundational framework (2010) presents three distinct pathways by which social determinants shape health results: conditions of daily life, structural drivers, and governance orientations.

One of the most important areas of sustainability in healthcare is resource allocation. Research by Sabokbar et al. (2021) and Peters et al. (2008) has shown that optimal healthcare infrastructure and equitable distribution of medical resources are factors that help make the healthcare system more sustainable and accessible. This involves investing in primary care services, telemedicine, and community-based interventions that minimize long-term reliance on emergency and specialized care services.

In addition, policy interventions focusing on long-term sustainability have been extensively studied. Blumenthal and Collins (2014) research on the Affordable Care Act (ACA) indicates that health policies that include sustainable funding pools, preventive care, and workforce development promote more equitable access to care. Barnes et al. (2022) further contend that it is possible to tackle systemic inequities through policy changes and that this increases healthcare sustainability by producing a resilient system that responds to

evolving demographic and economic trends.

Policy interventions are being suggested to address such inequalities. According to Daniels (2013) extending health insurance coverage to more vulnerable groups could minimize SES-based inequalities. Similarly, Krieger (2001) supported addressing SES as an important determinant in public health policy to emphasize socioeconomic equity in enhancing healthcare access among vulnerable populations.

Public health reforms, such as the Affordable Care Act, implemented in the United States (Blumenthal & Collins, 2014), have shown promise regarding the improvement of access to care for the poor (SES). However, several studies by Sommers et al. (2017) and Frean et al. (2017) reveal that while the ACA is somewhat reducing the disparities across income groups, significant holes still exist for the individuals with the lowest incomes.

Recent studies have broadened the discussion to include interactions of SES with other significant social determinants, like race and gender. For example, Williams et al. (2019) argue that while SES is indeed an underlying factor in influencing the accessibility of healthcare services, its influence is oftentimes compounded by race- and gender-based disparities. Second, Adler and Stewart (2010) argued that health inequalities related to SES are very much an integrated part of systemic racism as well as other sources of social exclusion.

These imbalances are, however, more conspicuous across international settings. For example, Nandi et al. (2016) examined access to health services in India and conclude SES as the leading cause for the inequities that happen in healthcare. Ataguba and Kabaniha (2022)have even opined a similar concern while doing a comparative analysis of health inequity issues in South Africa, as they prove significant outcomes of healthcare access using comparison between SES and race factors.

The placement of health facilities in space profoundly affects accessibility, according to an earlier work by Guagliardo (2004)). Inequalities in healthcare between urban and rural settings can be attributed to SES where poorer districts often show inadequate medical structures. This is further supported by the behavioral model of health care use from Andersen and Davidson (2007), which explains the interaction between SES determinants such as income and education with physical availability, thus limiting access to healthcare service.

Gordon et al.'s study on South African healthcare access revealed socioeconomic disparities (Becker and Newsom, 2003), with better and worse socioeconomic statuses leading to better health outcomes. The study found that the financially disadvantaged experienced unmet needs and delayed treatment, while the wealthy perceived greater demand for care Gordon et al. (2020a). The primary causes of these disparities are financial capacity and affordability. It is found in Philadelphia that neighborhood socioeconomic status affects their healthcare access. They found no evidence of worse access in low- income neighborhoods, but a correlation between increased reliance on safety net providers and decreased reliance on doctor offices Hussein et al. (2016). Another study done by McMaughan et al on the link between healthcare access, socioeconomic level, and healthy aging in older persons highlighted the need for interventions and research-guided action to address the trend of older age being associated with lower socioeconomic status, lack of access to care, and worse health outcomes McMaughan et al. (2020). In 1998 some researchers tried to identify the health care disparity between affluent and poor people and it’s found that if health disparity not existing people might have get a better chance to get the treatment /financial aid in terms of medical insurance for those who have diseases like HIV/AIDS etc Andrulis (1998). As per the Guidance for the National Healthcare Disparities Report (Medicine & Report, 2002), most of the social scientists believed that the socio-economic status when it comes to health is determined by health itself, but the opposite happens. Most research suggests that access to medical care plays a relatively minor role in explaining socioeconomic inequalities in health. socioeconomic differences are seen both in diseases that are amenable to medical treatment and in diseases that are not amenable to medical treatment with deaths from diseases amenable to treatment representing only a

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fraction of all deaths in any case (Robert & House, 2000) The availability and accessibility of reproductive health care services in India's Aspirational Districts are examined in the study by Debnath et al. (2023). Districts with high accessibility scores do not rank highly for healthcare availability, according to the results. The study comes to the conclusion that accessibility and availability have a big impact on healthcare access and health outcomes. In 2024 a research has been conducted to the performance of general practice in the English NHS using Starfield's framework for primary care. It suggested that policymakers should focus on funding general practices and assisting teams to improve local service quality. Farmer et al. (2013) also contend that health disparities are not the result of individual decisions but of deep-rooted structural disparities, such as poverty and rural remoteness, which are also consistent with the accessibility issues experienced in this study(Adler, N. E., & Stewart, J.,2010).

The present literature suggests that SES is an important determinant of accessibility to healthcare. Some of the key issues regarding determinants of income, education, place of residence, and policy framework determine access to healthcare among the people. In addition, other intersecting factors that come along with race and gender make these disparities worst by weaving a complex weave of inequities regarding access to public health care. Sketching through the above reviews, it is also to understand that, to analyse the influence of socio economic status on public health care access it is important to study whether the variables like income, education, and occupation, among the target demographic groups influence the public health care access or not.

MATERIALS AND METHODS

The study's methodology is exploratory because it scores the variables. The collected data include both qualitative and quantitative data. As a result, the study analyses data using both qualitative and quantitative methods. The research design measures major sustainability parameters like the affordability of healthcare, accessibility of fundamental services, efficacy in the usage of resources, and healthcare infrastructure resilience. It also examines government policies and interventions as drivers for sustainable access to healthcare, with a focus on low-income communities and underserved populations. The research takes into account how access to healthcare and policy effectiveness over time ensure the results represent long-term sustainability, not short-term interventions. Qualitative interviews and case studies add insight into the influence of sustainable interventions on the accessibility and equity of healthcare. Two stages made up the statistical analysis. The reliability and validity of the measures used in this study were evaluated in the first step by using the descriptive statistics of the variables being measured. The apparent variables path coefficients were evaluated for their contributions and significance as part of the second stage of testing the suitability of the methodology. Data analysis was done using SPSS 20.0 for Windows. The demographic characteristics of the sample collected from the respondents were summarized and described using descriptive statistics. For comparison of the factors taken into account between various levels of the demographic data, parametric statistics including one way ANOVA and Z-test were used.

The terms used in the research paper is defined as follow:

Beneficiary: Beneficiaries are those people who access the services of the family health centres at least once.

Accessibility: Accessibility is the ease with which the population can locate the provider, and it also constitutes the term ‘availability’ which refers to the presence of resources for the provider to offer the necessary care.

Affordability: Financial access, or if the healthcare is offered in accordance with the population's capability and willingness to pay for the treatments, it is referred to as affordability.

Continuity: Continuity of care refers to the coherent, interconnected and consistent experience of healthcare events.

Comprehensiveness: Comprehensiveness involves offering a wide range of services to meet all the

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patients' physical and mental healthcare needs.

People-Friendliness: It means a patient-friendly hospital with good staff, good facilities, adequate grounds, visual appearance and no unpleasant smell.

Communication: Communication assesses patient satisfaction with interpersonal relationships in family health centers.

Hygiene: It refers to the neatness of the family health center from different perspectives.

Public hospital: It is a hospital that is fully funded by the government, owned by the government and operates solely on revenues collected to help healthcare initiatives.

Participant (Subject) Characteristics

The study's primary participants were the beneficiaries and the key informants. Beneficiaries are those people who use and access the services that the FHCs offer. The data from beneficiaries were collected on a daily basis (from those who are approaching FHC for any services in the day of visit by the researcher) till the time it accounts for the sample size intended to collect from each FHC. Regarding getting the responses from palliative care patients, the researcher visited the FHC on the day each FHC were offered to the needy exclusively for palliative care patients. The socio- economic features have been examined using this data. The persons who give public healthcare to the beneficiaries are considered key informants. The key informants consist of doctors, nurses, the Aardram Mission nodal officers, officials of the Directorate of Health Services as well as those of the District Medical Office, etc.

Sampling Procedures

In order to obtain a suitable sample, data were acquired using a multi-stage random sampling procedure. Thiruvananthapuram, Idukki, and Kannur are the three Kerala districts that were initially chosen at random. In the following stage, five Family Health Centers were then selected in each of these districts using the lottery method of simple random selection. Beneficiaries have now been chosen at random for the third stage. The selected FHCs were Chemmaruthy FHC, Kilimanoor FHC, Navaikulam FHC , Ottoor FHC and Pazhayakunnummel FHC from the District of Thiruvananthapuram; Peruvanthanam FHC, Elappara FHC, Kumili FHC, Ayyappancoil FHC and Vattavada FHC from Idukki; and Cherupuzha FHC, Alakode FHC, Kankol-Alappadamba FHC, Peringome-Vayakkara FHC and Eramam-Kuttur FHC from Kannur respectively. Five consecutive months, i.e., the period from 29 December 2022 to 5 May 2023 were used to conduct the survey. The Thiruvananthapuram data gathering process began in December and finished on January 30. From 20 February to 5 May 2023, statistics from additional districts were gathered.

Sample Size, Power, and Precision

Population is a set of events or elements relevant to a given question or experiment. The finite population equation needs to be adjusted when considering a finite population, as the (N-n)/(N-1) term in the equation needs to be adjusted. An equation for calculating a confidence interval with an unlimited population is provided.

n= (z^2 X p (1-p̂))/ε^2 where

z = z score

ε = margin of error

p = population proportion

In the study, it is evident that the population who are accessing these particular services provided by the Government through the Aardram Mission is unknown. Mission Aardram is designed for transforming the primary health centres into family health centres by providing comprehensive health services at low cost. As a result, anyone can access the medical care offered by the family health centers, regardless of any form of discrimination. Therefore, it is uncertain what population uses the family health centers. So the population accessing the family health centres is unknown. Hence, the only possibility to find an adequate number of observations (sample) could be selected only through the equation mentioned above by assuming the confidence interval of 95%; then there would be a 5% chance for the researcher to commit error. The Z score can be 1.96 as 95% confidence level has -1.96 and +1.96 standard deviations.

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Hence the sample size could be Z=1.96p = 0.5

ε =0.05 n = (1.96〗^2 X 0.5 (1-0.5))/〖0.05〗^2

= (3.8416 X 0.5(0.5))/0.0025

= 3.8416X0.25/0.0025

=384.16

Approximately =385

Measures and Covariates

Data has been collected from beneficiaries through a structured questionnaire and interview had been conducted to collect data from key informants. Using Cronbach's alpha, the questionnaire's reliability is assessed. The initial Cronbach's alpha for each of the structures taken into consideration is shown in the table 1.

Table 1: Reliability Check

Variables	Cronbach's Alpha	No. of Variables
Accessibility	0.810	**7**
Continuity	0.826	**5**
People-friendliness	0.852	**6**
Comprehensiveness	0.823	**3**
Communication	0.831	**4**
Hygiene	**0.873**	**4**

Source: Primary Data

The findings indicate that most constructs have reliability levels over 0.8. So, it is possible to continue with the analysis. Before doing any statistical analysis, it is imperative to assess the data's normality since the statistical processes and tests for normal and non-normal data are different. In other words, distribution- free approaches for non-normal data and parametric test process for normal data were applied. The Kolmogorov-Smirnov test was applied to examine normality, and then the following hypotheses were tested.

Research Design

This study employs mixed methods exploratory design because it uses both qualitative and quantitative data. This study compares attributes across different demographic levels and it has been analysed to find the relationship between SES and the impact of the same on public healthcare access.

Clinical Trian Registration: This study is not a clinical trial. Clinical trial number: not applicable.

RESULTS

The population profile (table 2) of the 385 respondents presents a gender distribution, age group distribution, and level of education.

Table 2: Demographic Characteristics of Respondents

Variable	Category	Frequency	Percentage
Gender	Male	136	35.32 %
	Female	249	64.68%
Age group	0-10	12	3.12 %
	11-20	179	46.49%
	21 and above	194	50.39%
Educational Level	Illiterate	22	5.71%
	Primary	97	25.19%
	Secondary	137	35.58%
	Higher education	129	33.51%

Source : Primary data

The population profile of the 385 respondents presents a gender distribution, age group distribution, and level of education. The highest percentage of respondents is aged 21 and above (50.39%), followed by the 11-20 years category

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(46.49%). The highest proportion has achieved at least secondary education (35.58%), followed by 33.51% who have achieved higher education. Most of the respondents are illiterate, pointing to an educated population in general who are more likely to know and be interested in healthcare access matters. The predominance of the 21 and above category points to adults as the driving force behind perceptions of healthcare and accessibility. The high rate of educated respondents implies that the population is more likely to comprehend healthcare policies and services. The gender gap in the sample, where there are more women respondents, may also indicate more female involvement in public discourse on healthcare or issue with access.

Table 3: Awareness and Accessibility of Public Healthcare Services

Healthcare services	Accessibility (%)	Awareness (%)
Primary Healthcare Centers	75	80
Government Hospitals	100	70
Free Health Check-ups	40	35
Emergency Services	60	90

Source: Primary Data

The table 3 shows the proportion of respondents who aware and have access to various public healthcare facilities. Primary care centers have the highest proportion with 80% awareness, and 75% of respondents find them accessible. Government hospitals have the highest proportion with 70% awareness, and 100% are accessible. Free check-ups of health have the lowest proportion with 35% awareness, and 40% accessibility. But few people are aware of these services, reflecting a need for increased awareness programs. Emergency services have the lowest awareness level at 90%, with 60% accessibility. Even though 90% know about emergency services, only 60% perceive them as accessible. This suggests the need for policy interventions to enhance healthcare service accessibility and boost public awareness. Government hospitals are highly accessible but require improved awareness campaigns. Primary health centers are widely used, though awareness to accessibility is in small gap. Free health check-ups need greater promotion and better accessibility. Emergency services need greater accessibility, which needs urgent attention. Among a sample of 385 people (136 men and 249 women), the cross-tabulation table contrasts gender with the preference of healthcare (Public Hospital, Public Dispensary, or Private Hospital).

Table 4: Healthcare Facility Preferences by Gender Among Survey Respondents (n=385)

Gender * Preference of health care						
			Preference of health care			Total
			Public Hospital	Public Dispensary	Private Hospital	
Gender	Male	Count	104	18	14	136
		% within Gender	76.5%	13.2%	10.3%	100.0%
	Female	Count	188	28	33	249
		% within Gender	75.5%	11.2%	13.3%	100.0%
Total		Count	292	46	47	385
		% within Gender	75.8%	11.9%	12.2%	100.0%

Source: Primary Data

According to the findings, public hospitals are the healthcare option of choice for both genders, with 76.5% of men and 75.5% of women admiring them, while private hospitals are marginally preferred. The cross tabulation table 2 shows how 385 people's preferred method of receiving healthcare—public hospital, public dispensary, or private hospital—relates to their level of education.

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Table 5: Association Between Education Level and Healthcare Facility Preference

Education * Preference of health care						
			Preference of health care			Total
			Public Hospital	Public Dispensary	Private Hospital	
Education	Illiterate	Count	19	0	3	22
		% within Education	86.4%	0.0%	13.6%	100.0%
	Primary	Count	77	12	8	97
		% within Education	79.4%	12.4%	8.2%	100.0%
	Secondary	Count	96	21	20	137
		% within Education	70.1%	15.3%	14.6%	100.0%
	Higher Education	Count	100	13	16	129
		% within Education	77.5%	10.1%	12.4%	100.0%
Total		Count	292	46	47	385
		% within Education	75.8%	11.9%	12.2%	100.0%

Source: Primary data

The table 5 shows that public hospitals are the most preferred healthcare option across all education levels, with higher education showing a preference for private hospitals. Education influences perceived quality and preference for healthcare facilities.

Table 6 : Healthcare Access Patterns by Employment Status

Employment * Preference of health care						
			Preference of health care			Total
			Public Hospital	Public Dispensary	Private Hospital	
Employment	Student	Count	29	3	4	36
		% within Employment	80.6%	8.3%	11.1%	100.0%
	Daily Worker	Count	75	8	7	90
		% within Employment	83.3%	8.9%	7.8%	100.0%
	Government Employee	Count	30	9	10	49
		% within Employment	61.2%	18.4%	20.4%	100.0%
	Private	Count	44	18	18	80
	Employee	% within Employment	55.0%	22.5%	22.5%	100.0%
	Other	Count	114	8	8	130
		% within Employment	87.7%	6.2%	6.2%	100.0%
Total		Count	292	46	47	385
		% within Employment	75.8%	11.9%	12.2%	100.0%

Source: Primary Data

According to the table 6, private hospitals are favored by those with higher education, while public hospitals are the most popular choice for

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healthcare across all educational levels. Perceived quality and choice for healthcare facilities are influenced by education.

The study found a positive relationship between household income and the availability of public health services. Better access to specialized services, shorter wait times, and general satisfaction with public healthcare facilities were reported by higher-income groups. The use of healthcare was also significantly influenced by education level, with individuals with higher education levels being more aware of the options that were accessible. Professionals had easier access to public health facilities because they could afford ancillary expenses and seek care when they needed it. The absence of official social safety nets and erratic incomes presented greater challenges for the informal economy. Table 7 explains the distribution of beneficiary satisfaction levels at different paces by accessing the services rendered by the public health care center nearby.

Table 7: Distribution of Beneficiary Satisfaction Levels with Public Healthcare Services

Beneficiary satisfaction	***Frequency***	***Percent***
Medium	140	36.4
High	245	63.6
Total	385	100.0

Source: Primary Data

Out of the 385 beneficiaries investigated 140 indicated a medium level of satisfaction, while 63.6% reported a high level of satisfaction. 63.6% of the 385 respondents said they were very satisfied, and 36.4% said they were moderately satisfied. The majority expressed either moderate or high levels of satisfaction with the service or benefit, suggesting that people generally had a favorable opinion of the program or service under review.

Table 8 : Initial Log-Likelihood Model Fit Statistics for Healthcare Access Predictors

Model	Model Fitting Criteria	Likelihood Ratio Tests		
	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	415.071	88.746	7	<0.001
Final	326.325			

Source: Primary Data

The log likelihood model was created initially and the result is shown in the table 8. The first log likelihood value, 415.071, represents a model with simply a constant or intercept and no independent variable. A model's true log likelihood value, which takes into account all independent variables, is 326.325. It can conclude that there is a significant relationship between the dependent and independent variables if we set the significance at the 0.05 level. The model chi-square value, which is obtained as 88.746 and has a significance as p <0.001, is the difference between these two measures. In order to fit a model and ascertain the impact of several demographic parameters (gender, age group, education, employment, marital status, religion, and place of residence) on a particular outcome or dependent variable, a Likelihood Ratio Test is performed, and the results are shown in the table 5 The degrees of freedom (df), Chi-Square, -2 Log Likelihood of Reduced Model, and Significance (Sig.) are the primary markers.

Table 9: Likelihood Ratio Test Results for Demographic Predictors of Healthcare Access

Effect	Model Fitting Criteria	Likelihood Ratio Tests		
	-2 Log Likelihood of Reduced Model	Chi-Square	df	Sig.
Intercept	339.950	13.625	1	0.000
Gender	332.016	5.692	1	0.000
Age group	341.416	15.091	1	0.000
Education	333.908	7.584	1	0.006

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Employment	351.409	25.084	1	0.000
Marital Status	326.526	0.201	1	0.752
Religion	352.195	25.870	1	0.000
Place of residence	332.471	6.146	1	0.013

Source: Primary Data

The research applies a model fitting and likelihood ratio test to evaluate the significance of various factors to predict an outcome. The intercept is significantly important, which means that the baseline model already accounts for some variation in the outcome. Gender is a significant predictor, which implies that healthcare access or awareness varies considerably between males and females. Age group is significantly influential, i.e., varying age groups have varying levels of healthcare access or awareness. Education is significant statistically, i.e., literacy and education level have an impact on healthcare service use and awareness. Employment status is a significant determinant, i.e., employees might have varying levels of healthcare access as opposed to non-employees. Marital status is not important, i.e., it does not play an important role in shaping healthcare access or awareness. Religion plays an important role in healthcare access, perhaps because of differences in healthcare use rooted in culture or communities. Residence (urban versus rural) is important, indicating differences in healthcare availability and accessibility by location.

The table 10 shows the results of a logistic regression study that was done to look at the association between the likelihood of having "high" beneficiary satisfaction and a number of predictor variables, including gender, age group, education, occupation, marital status, religion, and place of residence. Based on these indicators, the regression model calculates the likelihood of a high degree of satisfaction as they have high accessibility of the services.

Table 10 : Logistic Regression Parameter Estimates for High Satisfaction With Healthcare Services

Beneficiary satisfaction-group		B	Std. Error	Wald	df	Sig.	Exp(B)
High	Intercept	18.530	0.833	495.280	1	0.000	
	Gender	0.608	0.255	5.704	1	0.000	1.837
	Age group	-0.895	0.238	14.153	1	0.000	0.408
	Education	-0.362	0.133	7.379	1	0.006	0.696
	Employment	0.455	0.094	23.508	1	0.000	1.576
	Marital Status	-0.087	0.194	0.201	1	0.752	0.917
	Religion	-0.823	0.165	25.013	1	0.000	0.439
	Place of residence	-16.090	0.000		1	0.013	0.000

Source: Primary Data

The impact of independent variables on high levels of accessibility is examined in this study. It concludes that a person's level of pleasure is highly influenced by their gender, age group, education, employment, marital status, religion, and place of living. While older age groups are less likely to indicate high satisfaction, men are more likely than women to report high satisfaction. While residency has a negative coefficient, religion is also significant.

The following equations are related to the multinomial logit model displayed in the table.

Log (p(Medium)/p(High)) = 18.530 + 0.608 (Gender) – 0.895 (Age group) – 0.362 (Education) +

0.455 (Employment status) - 0.087 (Marital status) - 0.823 (Religion) -16.090 (Place of residence)

An alternative interpretation of the outcome relies on the Exponential beta. The dependent variable's odd ratio is provided via exponential beta. This odd ratio allows us to calculate the probability of the dependent variable. The likelihood of the other category (High group) grows when the exponential

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beta value is larger than one, and the reference (middle) category probability increases when the exponential beta probability is less than one. When interpreting an exponential beta value, one uses the reference category to determine the likelihood that the dependent variable will rise or fall. When dealing with continuous variables, an increase or decrease of one unit in the independent variable is understood as equating to the same amount in the dependent variable. Based on this, it can be concluded that, for beneficiary satisfaction of the health services accessibility, gender and employment are the factors positively influencing the high satisfaction group as compared to the medium satisfaction group (See the column Exp(B)).

Table 11: Percentage of Respondents Reporting Barriers to Public Healthcare Access

Challenge	**Percentage (%)**
Long Waiting Time	90
Lack of Infrastructure	68
Insufficient Medical Staff	92
High Treatment Costs	40

Source: Primary Data

The table 11 shows the major problems faced by respondents in the access to public healthcare services. The biggest problem is long waiting time, which affects more than 90% of respondents. Overcrowding, inefficiency in service delivery, or a lack of adequate healthcare facilities is implied. Interventions such as adding more healthcare workers, adopting appointment systems, and increasing healthcare centers could alleviate waiting times. Inadequate infrastructure, for example, lack of proper hospital facilities, out-of-date equipment, insufficient beds, or improper sanitation, is recognized as a barrier to access to healthcare. Policy measures must aim at employing additional healthcare personnel, providing more incentives, and enhancing working conditions to keep personnel. Excessive treatment charges, especially among low-income groups, are also a barrier to access to healthcare. Increasing government- funded healthcare schemes, insurance schemes, and subsidized therapies can minimize the cost burden on patients.

Table 12: Public Support for Proposed Healthcare System Improvements

Recommendation	Support (%)
Increase Healthcare Funding	98
Hire More Medical Staff	75
Improve Infrastructure	92
Reduce Treatment Costs	49

Source: Primary Data

The table 12 offers suggestions for enhancing healthcare access, and 98% of those who responded favor increased government funding for healthcare. This would facilitate an increase in facilities, the purchase of new medical equipment, the employment of additional staff, and enhanced service quality. 75% of those responding think that enrolling more medical staff is important and that policies should target encouraging medical professionals, providing competitive pay, and enhancing conditions of work. Infrastructure is also highlighted, with 92% of respondents highlighting the improvement of healthcare infrastructure, such as constructing more hospitals, renovating existing facilities, enhancing medical equipment, and strengthening digital health services. Decreasing the cost of treatment is an issue, but 49% of respondents consider it an issue. Policymakers need to target a holistic approach, balancing increased investment, expansion of the workforce, development of infrastructure, and improvement of

financial accessibility.

Despite of all these , access to healthcare is greatly impacted by cultural norms and beliefs, especially for vulnerable groups. Particularly in the case of indigenous populations, traditional beliefs in rural and low-income areas can cause delays in the use of contemporary services. Although they increase access, policy frameworks such as government healthcare programs are not always well-communicated or used. Access to healthcare is also influenced by geographic location, with rural communities having less access because of poor infrastructure, problems with transportation, and a lack of medical experts. A divided geographical sense of availability of healthcare emerges. This study elucidates how the relations between socioeconomic position and public healthcare access are largely moderated by particular frameworks of policy-making, circumstances of the milieu, and cultural norms. Daily cultural impediments work against receiving contemporary healthcare treatments, especially in rural and indigenous communities. Similarly, programs instituted by the Indian government to cut healthcare costs often remain underutilized, especially in rural and lower-class communities. This is compounded by the failure of effective communication strategies on public health policies. Policymakers may develop new healthcare interventions that are aware of cultural differences; educate providers about building rapport with patients from various cultural backgrounds; improve communication strategies on public health policies; and reduce the divide between rural and urban healthcare via infrastructure and transport enhancement. This systematic strategy could serve to combine within it how policymakers may proceed with culturally sensitive interventions that might lead to legislative amendments and infrastructure improvements to bring public healthcare systems into a direction that is accessible and embracing extension-like.

DISCUSSION

Sustainability in healthcare as indicated by the findings of the current study helps to mitigate socioeconomic inequalities. Resource-efficient healthcare models, preventive services, and effective incorporation of healthcare delivery innovations all contribute to well-functioning, sustainable healthcare that maintains access uninterrupted. The resilience and sustainability needs of healthcare structures have been reiterated by the global pandemic of the COVID-19 virus, such that short-term interventions are simply not enough. Sustainable health policies thus need to focus on long-term investment in health infrastructure, education, and workforce capacity to build an adaptive and inclusive system. By integrating sustainability principles, policymakers can formulate strategies that not only improve existing healthcare accessibility but also future-proof the system against financial, demographic, and epidemiological pressures.The present study, " Sustainable Public Healthcare Access: The Role of Socioeconomic Status in Achieving Equity and Resilience," was conducted to investigate factors through which socioeconomic factors affect availability. The socioeconomic factors include the distribution by income groups and educational and professional status, among others, with spatial heterogeneity. This section provides a review of the research results against the background of other relevant research works, presents theoretical and applied significance for the works, and introduces several lines of further research inquiry. The results reveal high SES correlation with access to health care, which is consistent with most conclusions drawn by several studies in the same sphere. Specifically, patients representing higher classes of SES tend to have a greater opportunity to receive timely and wholesome health care services than people with lower classes of SES: the same conclusion was drawn by Wagstaff and Neelsen (2019) and Marmot (2015), who considered the role of economic differentiation in the generation of inequalities in terms of access to health services. This study's results imply that sustainability needs to be the underlying principle when responding to SES-associated healthcare disparities. Sustainable health care systems are those that utilize resources efficiently, emphasize preventive services, and combine new models of health care delivery in order to maintain ongoing access. In the absence of long-term vision, health care interventions will end up being reactive, not proactive, and thus failing to solve deeper causes of inequity.Sustainable health policies must aim to decrease systemic obstacles through enhanced infrastructure, increased insurance coverage, and encouragement of digital health solutions. The

function of primary healthcare facilities is paramount in guaranteeing sustainable access, particularly for low-income individuals. In addition, sustainability-oriented policies must include health education, preventive services, and workforce development to establish a robust healthcare system that adjusts to demographic and economic shifts over time. The COVID-19 pandemic has further emphasized the necessity of robust and sustainable healthcare infrastructures since short-term interventions tend to do little to change the underlying inequities in access. Long-term investments in health infrastructure, education, and workforce capacity must thus be given priority in sustainable healthcare policies in order to build a system that is adaptive and inclusive. By integrating principles of sustainability, policymakers can formulate policies that not only improve existing healthcare accessibility but also future-proof the system against financial, demographic, and epidemiological pressures. However, the study brings forth several complexities that contrast with previous research findings. One important finding is the impact of education as a determinant for healthcare access and, in some cases, tends to be

This study's findings in areas of socioeconomic determinants of health access reveal complex characteristics and challenge the assumption that income is the direct causal influence on disparities. The significantly positive effect of educational status reveals that health literacy should be a key target for public health interventions, especially at reduced income levels, since this can dramatically affect the intake of healthcare. These results have immediate implications for policy: interventions aimed at healthcare access should be multifaceted, focusing not only on income-related constraints but also on education-related gaps. It further nourishes the theoretical models on disparities in health research, especially by enriching the knowledge of the interaction between socioeconomic factors. The interdisciplinary research approach, combining the factors of economics, public health, and sociology here, can provide a more holistic outlook on access-related disparities. This concurs with the postulation of Andersen (1995) that access to medical care is a function of the interaction of predisposing, enabling, and need factors; however, our study implies that educational determinants deserve more prominence than traditionally

even more crucial than income, particularly during urban populations. This conclusion is somewhat contrary to the assumptions of Galobardes et al. (2007) who reported that income usually is the leading variable while predicting healthcare accessibility. This study shows increased educational levels make it easier for patients to navigate through the healthcare system. In other words, their health literacy becomes a critical tool for refining healthcare results when income levels seem stable. The educational interventions, therefore, need to be backed by other economic support programs toward achieving more even healthcare access. Moreover, although previous studies emphasized the geographical barriers that exist in rural settings, our study revealed an emerging trend of healthcare access issues in semi-urban areas. This may be related to the new trends of urbanization and health care facilities, which have been relatively less discussed in academic literature. In brief, the traditional distinction applied to rural and urban accessibility of healthcare may need a reevaluation, particularly in respect of change in public health policy impacts on semi-urban areas.
assigned. These results support the WHO's (2010) appeal for multisectoral interventions to deal with the social determinants that cause health inequities among groups.

Methodological Approaches and Statistical Examination of Evaluation This study applied the utilization of regression models to analyze the association that exists between various SES factors and access to health care. The model was quite robust, and it did adjust for potential confounders; however, in some ways, this study is limited by reliance on self-reported data and potential bias. This cross- sectional design limits our ability to draw causal relationships between SES and access to health care, which should be longitudinal in design. Future studies should address these limitations by using longitudinal approaches and assessing other factors, such as cultural or behavioral, which could better explain the inequalities in access to health care.

This research opens up multiple avenues for further study. In the first instance, more research needs to be carried out to see how the importance of semi-urban areas relates to improving healthcare facilities since, apparently, it has somewhat

different issues compared to merely rural or purely urban. In addition, the results imply that further research should be conducted to identify specific mechanisms through which education affects access to health care services, such as health literacy and empowerment. Ultimately, more research concerning the accessibility of health care for these at-risk populations—mainly ethnic minorities and migrants—would add to the existing knowledge regarding how intersectional factors affect disparities in healthcare. In brief, this current study focused on how socioeconomic status played a significant role in predicting healthcare access while calling for evaluation that includes further determinants like education and geographical components. These results clearly indicate that there is a need for more targeted strategies within public health policy initiatives that will reduce economic disparities as well as educational disparities so that all can have some measurable improvements in overall health outcomes and increased access to healthcare. Healthcare access structural barriers disproportionately impact marginalized groups, perpetuating cycles of inequity (Farmer et al., 2013). This research considers how socioeconomic status (SES) worsens such disparities within public healthcare systems.

CONCLUSIONS

To secure sustainable access to public healthcare, there must be an overall consideration that encompasses economic, social, and environmental factors. This research highlights the necessity of sustainable policy measures that enhance long-term health care accessibility, equity, and resilience. By addressing sustainable health financing, human resource development, and innovative service delivery models, policymakers can reduce the differences brought about by socioeconomic status and improve the overall effectiveness of public health care systems. A move towards policies based on sustainability will play a key role in creating a more resilient and inclusive health system that benefits current and future generations. The study points out how socioeconomic status relates to public health care in accessing accessible public healthcare, whereby patients with low SES face serious barriers such as financial constraints, education, and fewer facilities, thus raising the issue of health inequities (Becker and Newsom,2003). Public access to healthcare is constrained by wealth and socio-economic status, religions, patterns of living, policies, and environmental effects, studies reveal. An integrated approach in the form of policy adjustments, cultural education, and infrastructure renovation is important for achieving inclusive healthcare. This holistic understanding may provide the solicitors and health professionals with a template to grasp the actions. Access to public health provision is greatly influenced by socio-economic classes, with occupation, education, and income all playing roles. Higher socio-economic groups have access because they are better informed, flexible in their work regimen, and much more able financially. Low SES populations face systematic barriers like limited job opportunities, lack of awareness, and affordability. The policy implications include funding low-income populations, investing in public education about available health services, and allowing informal and unskilled workers flexible access to health care. This program will additionally facilitate improved access to health care and give some relief from out-of-pocket liabilities.

The study highlights significant impact of socioeconomic status (SES) on people's access to public healthcare service. People from lower SES are generally at a disadvantage in accessing basic healthcare services, adversely impacting their health condition. Cultural, political, and environmental factors also mediate the relationship between SES and healthcare accessibility. The effect of SES on healthcare consumption may be moderated or worsened by immediate factors such as availability of healthcare facilities, offer of health programs, and environmental issues. The study demonstrates the need for integrated policy approaches enveloping economic, sociocultural factors behind health as well as environmental determinants of health. The inclusive public health systems, cognizant of multiple dimensions of SES, shall contribute to achieve a major reduction in health inequalities.

Guaranteeing sustainable access to public healthcare involves a multidimensional strategy that incorporates economic, social, and environmental factors. This research highlights the necessity of sustainable policy interventions that ensure long-term accessibility, equity, and resilience in healthcare. Through sustainable health

financing, human resource development, and new models of service delivery, policymakers can reduce the inequalities brought about by socioeconomic status and improve the overall efficiency of public healthcare systems. Major recommendations for ensuring sustainable health access are Viz.., Enlarging the coverage of healthcare to make sure that budget limitations do not prohibit access to main services, promoting stable and sustainable healthcare financing mechanisms in order to less depend on short-term or donor-based funding, enhancing local health programs to deliver culturally responsive, accessible, and preventive care solutions for the needs of low-income and marginalized communities, emphasizing early diagnosis, vaccinations, and chronic disease care to contain long-term healthcare expenditures and enhance population health outcomes and utilizing telemedicine and digital health platforms to close healthcare access gaps, especially in rural and underserved regions. A transition towards health policies based on sustainability will be crucial in developing a more equitable and resilient health system that benefits current and future generations uniformly. Through the implementation of long-term strategies that are based on equity, resilience, and accessibility, policymakers can develop a sustainable public healthcare system that effectively combats SES-related inequalities. As Farmer et al. (2013) put it, solutions to sustainable healthcare have to solve deep causes of inequity like the distribution of resources and social determinants of health instead of temporary remedies.

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