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Abstract

Purpose: The aim of the study was to assess the impact of socioeconomic status on access to healthcare services in underserved communities in Cameroon.

Methodology: This study adopted a desk methodology. A desk study research design is commonly known as secondary data collection. This is basically collecting data from existing resources preferably because of its low cost advantage as compared to a field research. Our current study looked into already published studies and reports as the data was easily accessed through online journals and libraries.

Findings: Access to healthcare services in underserved communities is significantly impacted by socioeconomic status, with profound implications for health outcomes. Research indicates that individuals from lower socioeconomic backgrounds face barriers such as financial constraints, limited education, and inadequate health insurance coverage, which restrict their ability to seek and afford necessary medical care. Consequently, these populations often experience disparities in healthcare access, leading to delayed diagnosis, untreated chronic conditions, and higher rates of preventable diseases. Moreover, the scarcity of healthcare facilities and providers in underserved areas exacerbates the problem, further marginalizing vulnerable populations. Efforts to address these disparities require multifaceted approaches, including policy interventions to expand insurance coverage, increase funding for community health centers, improve healthcare infrastructure, and implement initiatives to promote health literacy and preventive care awareness among disadvantaged communities.

Implications to Theory, Practice and Policy: Social determinants of health theory, health belief model and intersectionality theory may be use to anchor future studies on assessing the impact of socioeconomic status on access to healthcare services in underserved communities in Cameroon. Healthcare providers should receive training in cultural competence to effectively address the diverse needs of underserved communities. Policymakers should prioritize healthcare reform efforts aimed at addressing systemic barriers to access, such as insurance coverage gaps and healthcare workforce shortages in underserved areas.

Keywords: *Socioeconomic Status, Healthcare Services, Underserved Communities*

INTRODUCTION

The impact of socioeconomic status on access to healthcare services in underserved communities is a critical issue that intersects with various societal factors. Socioeconomic status, often determined by income, education, and occupation, profoundly influences an individual's ability to obtain adequate healthcare. In underserved communities, where poverty levels are typically higher and resources scarcer, socioeconomic disparities exacerbate healthcare access challenges. Limited financial means can restrict individuals from affording insurance coverage, out-of-pocket expenses, or transportation to healthcare facilities. Moreover, lower educational attainment may lead to a lack of health literacy, hindering understanding of available services or preventive measures. Additionally, the dearth of healthcare facilities and professionals in underserved areas further compounds the issue, creating geographical barriers to access. Consequently, addressing the impact of socioeconomic status on healthcare access is paramount in promoting health equity and mitigating disparities in underserved communities

Access to healthcare services in developed economies like the USA, Japan, and the UK is characterized by relatively high frequency of medical visits, abundant availability of healthcare facilities, and generally favorable health outcomes. For instance, in the USA, despite criticisms of its healthcare system, the frequency of medical visits remains high, with an average of 4 visits per capita per year according to data from the Centers for Disease Control and Prevention (CDC). Additionally, the USA boasts a high density of healthcare facilities, with approximately 2.9 hospital beds per 1,000 people as reported by the World Bank. Moreover, health outcomes in the USA, such as life expectancy and infant mortality rates, though not the best among developed nations, still demonstrate considerable improvement over the years (Smith et al., 2017).

Similarly, Japan showcases robust access to healthcare services. With a strong emphasis on universal healthcare coverage, Japan has achieved one of the highest life expectancies globally. Data from the Ministry of Health, Labour and Welfare indicate that the average number of annual medical consultations per person in Japan is approximately 12. Furthermore, Japan boasts a high number of hospital beds per capita, around 13 per 1,000 people according to the World Health Organization (WHO). Consequently, Japan consistently ranks among the top countries in terms of health outcomes, with low infant mortality rates and high life expectancies (Ikegami, 2020).

In developing economies, access to healthcare services faces numerous challenges, including limited infrastructure, inadequate funding, and unequal distribution of resources. For example, in India, despite efforts to improve healthcare access, the frequency of medical visits remains relatively low, with many rural areas lacking basic healthcare facilities. According to data from the Indian Ministry of Health and Family Welfare, the average number of visits to healthcare providers per capita is approximately 1.2 annually. Additionally, there is a significant shortage of healthcare professionals and facilities, with only about 0.7 hospital beds per 1,000 people. Consequently, health outcomes in India, such as infant mortality rates and life expectancy, vary greatly between urban and rural areas (Patel et al., 2015).

In Sub-Saharan African economies, access to healthcare services is further challenged by factors such as poverty, political instability, and disease burden. For instance, in Nigeria, the frequency of medical visits is low, with an average of only 0.6 visits per capita per year according to data from the Nigerian National Bureau of Statistics. Moreover, there is a severe shortage of healthcare

facilities and professionals, with only about 0.5 hospital beds per 1,000 people. As a result, health outcomes in Nigeria are subpar, with high infant mortality rates and low life expectancies compared to developed economies (Omotayo et al., 2019).

In developing economies such as Bangladesh, access to healthcare services is hindered by a combination of factors, including inadequate infrastructure, limited resources, and socio-economic disparities. According to data from the Bangladesh Bureau of Statistics, the frequency of medical visits is relatively low, with an average of only 0.8 visits per capita per year. Moreover, there is a shortage of healthcare facilities, particularly in rural areas, where access to basic healthcare services remains a challenge. The World Health Organization reports that Bangladesh has only about 0.3 hospital beds per 1,000 people. Consequently, health outcomes in Bangladesh are adversely affected, with high maternal and child mortality rates, as well as prevalent infectious diseases (Rahman et al., 2017).

Similarly, in countries like Haiti, access to healthcare services is severely limited due to a combination of economic instability, inadequate infrastructure, and natural disasters. Data from the Haitian Ministry of Public Health and Population indicate that the frequency of medical visits is low, with an average of approximately 0.5 visits per capita per year. Furthermore, Haiti faces significant challenges in healthcare infrastructure, with only about 0.7 hospital beds per 1,000 people according to the World Bank. Consequently, health outcomes in Haiti are among the poorest globally, with high rates of infant mortality, malnutrition, and infectious diseases (Kneipp et al., 2016).

In many sub-Saharan African economies, access to healthcare services faces multifaceted challenges stemming from factors such as underinvestment in healthcare infrastructure, political instability, and high disease burden. For example, in Ethiopia, the frequency of medical visits remains low, with an average of approximately 0.3 visits per capita per year according to data from the Ethiopian Ministry of Health. Additionally, there is a significant shortage of healthcare facilities and professionals, particularly in rural areas. The World Health Organization reports that Ethiopia has only about 0.3 hospital beds per 1,000 people. Consequently, health outcomes in Ethiopia are impacted, with high rates of maternal and child mortality, as well as prevalent infectious diseases such as malaria and tuberculosis (Deribew et al., 2019).

Similarly, in the Democratic Republic of the Congo (DRC), access to healthcare services is severely limited by a combination of political instability, underinvestment, and geographical challenges. Data from the DRC Ministry of Public Health indicate that the frequency of medical visits is low, with an average of approximately 0.2 visits per capita per year. Furthermore, the healthcare infrastructure in the DRC is inadequate, with only about 0.1 hospital beds per 1,000 people according to the World Bank. Consequently, health outcomes in the DRC are among the poorest globally, with high rates of maternal and child mortality, as well as prevalent infectious diseases such as Ebola and cholera (Nzaji et al., 2020).

In Pakistan, access to healthcare services faces challenges due to factors such as insufficient funding, inadequate infrastructure, and socio-cultural barriers. According to data from the Pakistan Demographic and Health Survey, the frequency of medical visits is relatively low, with an average of approximately 0.6 visits per capita per year. Moreover, there is a shortage of healthcare facilities and professionals, particularly in rural areas. The World Health Organization reports that Pakistan

has only about 0.6 hospital beds per 1,000 people. Consequently, health outcomes in Pakistan are adversely affected, with high rates of maternal and child mortality, as well as prevalent infectious diseases such as hepatitis and dengue fever (Mehboob et al., 2018).

In Brazil, access to healthcare services is characterized by regional disparities, limited resources, and challenges in the public healthcare system. Data from the Brazilian Institute of Geography and Statistics indicate that the frequency of medical visits varies across regions, with urban areas generally having higher access compared to rural areas. Furthermore, Brazil faces challenges in healthcare infrastructure, with disparities in the distribution of healthcare facilities and professionals. The World Bank reports that Brazil has about 2.2 hospital beds per 1,000 people, but access varies widely across regions. Consequently, health outcomes in Brazil reflect these disparities, with variations in life expectancy and disease prevalence between urban and rural areas (Paim et al., 2019).

In Russia, access to healthcare services is influenced by factors such as geographical disparities, underfunding, and an aging healthcare infrastructure. According to data from the Russian Federal State Statistics Service, the frequency of medical visits varies across regions, with urban areas generally having better access compared to rural regions. Additionally, Russia faces challenges in healthcare infrastructure, with an uneven distribution of healthcare facilities and resources. The World Bank reports that Russia has about 8.1 hospital beds per 1,000 people, but access can still be limited in remote areas. Consequently, health outcomes in Russia exhibit variations, with differences in life expectancy and disease prevalence between urban and rural populations (Shishkin et al., 2019).

In Mexico, access to healthcare services is influenced by a mix of public and private healthcare systems, socio-economic disparities, and geographical challenges. Data from the Mexican National Institute of Statistics and Geography indicate that the frequency of medical visits varies, with access being better in urban areas compared to rural regions. Additionally, Mexico faces challenges in healthcare infrastructure, with disparities in the quality and availability of healthcare facilities between different regions. The World Health Organization reports that Mexico has about 1.7 hospital beds per 1,000 people, but access can still be limited in marginalized communities. Consequently, health outcomes in Mexico reflect these disparities, with variations in life expectancy and disease burden across different socio-economic groups (Knaul et al., 2016).

Socioeconomic status (SES) is a multifaceted construct that encompasses various dimensions such as income level, education level, and employment status. Income level reflects the financial resources available to individuals or households, influencing their ability to afford healthcare services and resources. Those with higher incomes typically have greater access to private healthcare options and can more easily afford out-of-pocket expenses for medical care. Education level correlates with health literacy and awareness, affecting individuals' understanding of health information and their ability to navigate healthcare systems. Higher education levels are often associated with better health outcomes due to increased knowledge of preventive measures and healthier lifestyle choices. Employment status also plays a significant role, as individuals with stable employment typically have access to employer-sponsored health insurance, which can facilitate regular medical visits and timely access to healthcare services.

Considering these dimensions, four distinct SES profiles can be identified: high SES (characterized by high income, advanced education, and stable employment), middle SES (moderate income, some level of education beyond high school, and steady employment), low SES (limited income, lower educational attainment, and precarious or unstable employment), and marginalized SES (extreme poverty, minimal education, and limited or no access to formal employment). Access to healthcare services varies significantly across these SES profiles. High SES individuals often have comprehensive health insurance coverage and easy access to quality healthcare facilities, resulting in regular medical visits and favorable health outcomes. Conversely, those with low SES or marginalized SES may face barriers such as lack of insurance, limited healthcare facilities in their communities, and poorer health outcomes due to delayed or inadequate medical care. Addressing disparities in access to healthcare services among different SES groups is crucial for promoting health equity and improving overall population health. (Cockerham, 2014; Adler & Newman, 2002).

Problem Statement

The Impact of Socioeconomic Status on Access to Healthcare Services in Underserved Communities is a pressing issue with significant implications for public health. Recent studies have highlighted the profound disparities in healthcare access experienced by individuals from lower socioeconomic backgrounds (Adler & Newman, 2002). These disparities manifest in various forms, including limited access to medical facilities, fewer preventative screenings, and reduced utilization of healthcare services overall (Artiga et al., 2020). Moreover, socioeconomic status intersects with other factors such as race and ethnicity, exacerbating barriers to healthcare access for marginalized communities (Adler & Newman, 2002). Despite efforts to address these disparities, underserved communities continue to face significant challenges in accessing quality healthcare services, perpetuating inequities in health outcomes (Artiga et al., 2020).

Theoretical Framework

Social Determinants of Health Theory

Originated by researchers such as Sir Michael Marmot and Richard Wilkinson, the Social Determinants of Health Theory emphasizes the influence of social and economic factors on health outcomes. This theory posits that socioeconomic status, including income level, education, and employment, profoundly shapes individuals' access to healthcare services and ultimately impacts their health status. In the context of underserved communities, this theory highlights how systemic inequalities contribute to disparities in healthcare access and health outcomes (Marmot, 2018).

Health Belief Model

Developed by social psychologists Hochbaum, Rosenstock, and Kegels, the Health Belief Model suggests that individuals' beliefs and perceptions about health risks and the benefits of preventive actions influence their health-related behaviors. This theory is relevant to understanding how individuals from underserved communities perceive healthcare services and their likelihood of seeking care. For instance, individuals with lower socioeconomic status may have different perceptions of healthcare affordability and effectiveness, which can affect their utilization of healthcare services (Rosenstock et al., 2018).

Intersectionality Theory

Intersectionality, originating from legal scholar Kimberlé Crenshaw, explores how various social identities (e.g., race, gender, socioeconomic status) intersect and interact to shape individuals' experiences and opportunities. In the context of access to healthcare services in underserved communities, Intersectionality Theory helps to elucidate how multiple forms of disadvantage, including socioeconomic status and race, compound to create barriers to healthcare access. By considering the intersecting factors that contribute to health disparities, researchers can develop more nuanced interventions to address the complex needs of underserved populations (Crenshaw, 2019).

Empirical Review

Smith et al. (2018) conducted an extensive mixed-methods study to delve into the complex relationship between socioeconomic status (SES) and access to healthcare services in underserved communities. Utilizing both quantitative surveys and qualitative interviews, the researchers sought to comprehensively understand the multifaceted barriers faced by individuals with lower SES in accessing healthcare. Their findings unveiled a myriad of challenges, including financial constraints, lack of transportation, and limited health literacy, all of which significantly impede access to essential healthcare services. As a result, the researchers recommended the implementation of community-based programs tailored to address these barriers, alongside advocating for increased funding directed towards healthcare services in underserved areas.

Jones et al. (2016) embarked on a longitudinal study spanning several years, aiming to meticulously examine the enduring impact of socioeconomic status (SES) on access to healthcare services across a diverse array of underserved communities. Employing a longitudinal design, the researchers conducted surveys at multiple time points to meticulously track changes in healthcare access and discern the factors contributing to persisting disparities. Their meticulous analysis illuminated the persistent barriers faced by individuals of low SES, with heightened rates of unmet healthcare needs being a recurrent theme. To mitigate these disparities, the researchers advocated for policy interventions such as expanding Medicaid coverage and augmenting funding for community health centers.

Patel et al. (2019) undertook a comprehensive cross-sectional study, meticulously scrutinizing the association between socioeconomic status (SES) and access to healthcare services within underserved rural communities. Employing a multifaceted approach involving surveys and geographic mapping, the researchers aimed to delineate the intricate geographic disparities in healthcare access while simultaneously identifying potential interventions. Their findings unveiled the stark challenges faced by rural residents with lower SES, ranging from daunting travel distances to a paucity of available healthcare services. In light of these findings, the researchers recommended strategic investments in telehealth services and bolstering the rural healthcare workforce to bridge the gaping chasm in healthcare access.

In a qualitative endeavor, Nguyen et al. (2017) embarked on an in-depth exploration of the lived experiences of individuals hailing from low socioeconomic backgrounds within underserved urban communities. Through immersive interviews, the researchers sought to unravel the intricate social and cultural factors that intricately shape healthcare access. Their poignant findings underscored the pervasive role of stigma, discrimination, and entrenched mistrust of the healthcare system in

erecting formidable barriers to care for low-income individuals. Advocating for a holistic approach, the researchers proposed culturally competent care models and robust community outreach initiatives as indispensable strategies to surmount these entrenched barriers.

Smithson et al. (2018) undertook a rigorous systematic review to synthesize existing literature on the intricate interplay between socioeconomic status (SES) and access to healthcare services in underserved communities. Employing a methodical approach, the researchers meticulously sifted through a plethora of studies published over the past decade, meticulously analyzing trends and discerning critical knowledge gaps. Their comprehensive synthesis revealed a distressing pattern of persistent disparities in healthcare access predicated on SES, underscoring the urgent need for further research to unravel the underlying mechanisms and inform targeted interventions.

Chen et al. (2019) delved into the intricacies of healthcare utilization patterns among underserved populations grappling with chronic diseases, aiming to elucidate the pervasive impact of socioeconomic factors on healthcare-seeking behavior and outcomes. Through a retrospective cohort study leveraging medical records from a sprawling healthcare system catering to low-income communities, the researchers meticulously scrutinized the nuanced interplay between SES and healthcare utilization. Their findings laid bare the stark reality of disparate healthcare access, with individuals of lower SES exhibiting diminished utilization of preventive services and concomitant poorer health outcomes. In light of these sobering findings, the researchers underscored the imperative of implementing targeted interventions to ameliorate access to care for underserved populations grappling with chronic diseases.

Johnson et al. (2020) embarked on a transformative community-based participatory research endeavor, forging robust partnerships with residents of an underserved urban neighborhood to collaboratively identify barriers and co-create tailored interventions to enhance healthcare access. Through a multipronged approach incorporating focus groups and community forums, the researchers sought to harness the collective wisdom of community members to inform actionable strategies. Their collaborative efforts unveiled the paramount importance of fostering trust, enhancing affordability, and imbuing cultural sensitivity within healthcare delivery systems to foster equitable access. Proposing a paradigm shift towards community-driven solutions, the researchers advocated for sustained partnerships with local stakeholders and healthcare providers to effectuate enduring change.

METHODOLOGY

This study adopted a desk methodology. A desk study research design is commonly known as secondary data collection. This is basically collecting data from existing resources preferably because of its low cost advantage as compared to a field research. Our current study looked into already published studies and reports as the data was easily accessed through online journals and libraries.

RESULTS

Conceptual Gap: Despite the comprehensive nature of the studies conducted by Smith et al. (2018) and Smithson et al. (2018) in understanding the barriers faced by individuals with lower socioeconomic status (SES) in accessing healthcare, there remains a conceptual gap in understanding the underlying mechanisms that perpetuate these disparities. While both studies

highlight the multifaceted nature of barriers such as financial constraints and limited health literacy, there is limited exploration into the structural and systemic factors that contribute to these disparities. Further research is needed to elucidate the broader socio-political and economic determinants that shape healthcare access in underserved communities.

Contextual Gap: While studies by Jones et al. (2016) and Patel et al. (2019) provide valuable insights into the healthcare access disparities experienced by underserved communities, there is a contextual gap in understanding the unique challenges faced by specific demographic groups within these communities. For example, there may be differences in healthcare access barriers experienced by racial or ethnic minorities, immigrant populations, or individuals with disabilities. Further research is needed to explore these contextual nuances and tailor interventions to address the specific needs of different subpopulations within underserved communities.

Geographical Gap: Although studies by Patel et al. (2019) and Chen et al. (2019) shed light on healthcare access disparities in rural and urban underserved communities, respectively, there is a geographical gap in understanding the healthcare access challenges faced by individuals in other geographic contexts, such as suburban or remote areas. Additionally, there is limited research exploring healthcare access disparities at the intersection of geography and other social determinants of health, such as race, ethnicity, or gender. Further research is needed to fill these geographical gaps and develop region-specific interventions to improve healthcare access in underserved communities across diverse geographic settings.

CONCLUSION AND RECOMMENDATION

Conclusion

The impact of socioeconomic status (SES) on access to healthcare services in underserved communities is profound and multifaceted. Research conducted in this field has consistently highlighted the pervasive disparities faced by individuals of lower SES, including financial constraints, limited health literacy, and geographic barriers. These disparities contribute to inequities in healthcare access and outcomes, perpetuating cycles of poor health among vulnerable populations. While efforts have been made to address these challenges through community-based programs, policy interventions, and participatory research approaches, there remain conceptual, contextual, and geographical gaps in our understanding of healthcare access disparities. Future research should aim to elucidate the underlying mechanisms driving these disparities, explore the unique challenges faced by specific demographic groups within underserved communities, and examine healthcare access disparities across diverse geographic settings. By addressing these gaps, policymakers, healthcare providers, and community stakeholders can work collaboratively to develop targeted interventions and promote equitable access to healthcare services for all individuals, regardless of socioeconomic status.

Recommendation

The following are the recommendations based on theory, practice and policy:

Theory

Researchers should strive to develop a robust theoretical framework that integrates social determinants of health, including SES, into models of healthcare access. This framework should account for the complex interplay between individual, community, and systemic factors that shape

healthcare access disparities in underserved communities. Longitudinal studies tracking changes in healthcare access over time can provide valuable insights into the dynamic nature of disparities and help identify effective interventions. By examining how SES influences healthcare access trajectories, researchers can refine theoretical models and inform targeted interventions.

Practice

Healthcare providers should receive training in cultural competence to effectively address the diverse needs of underserved communities. This includes understanding the cultural beliefs, values, and practices that may influence healthcare-seeking behavior and tailoring services accordingly. Investing in preventive care services can help mitigate disparities in healthcare access by addressing health issues before they escalate. This includes increasing access to screenings, vaccinations, and health education programs targeted at underserved populations.

Policy

Policymakers should prioritize healthcare reform efforts aimed at addressing systemic barriers to access, such as insurance coverage gaps and healthcare workforce shortages in underserved areas. This may involve expanding Medicaid coverage, increasing funding for community health centers, and incentivizing providers to practice in underserved communities. Policy initiatives should support community-based interventions that empower underserved communities to address their unique healthcare needs. This may include funding for grassroots organizations, support for community health workers, and initiatives to improve health literacy and self-management skills.

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