Gurukul International Multidisciplinary Research Journal (GIMRJ)*with* International Impact Factor 8.357
Peer Reviewed Journal
https://doi.org/10.69758/GIMRJ/2505I5VXIIIP0078

e-ISSN No. 2394-8426
Monthly Issue
MAY-2025
Issue–V, Volume–XIII

Social Determinants and Healthcare-Seeking Patterns: A Sociological Analysis

Dichen Lamu Sherpa
Assistant Professor
Department of Sociology
Birsa Munda College, Darjeeling

Abstract
The paper examines the connection between social class and healthcare-seeking behavior. It delves into the ways socio-economic stratification affects access and use of healthcare services based on sociological theories including Marxism, Weberian theory, and Bourdieu's capital theory. The paper depicts the ways in which class-based disparities influence people's health conditions and behaviors. The principal argument of this research is that health-seeking behavior is not merely a question of individual choice but is deeply influenced by structural issues related to class. The article proposes that social class continues to be a core determinant of healthcare access and decision-making, shaped by economic means, cultural norms, and institutional constraints. Keywords: Social class, healthcare-seeking behavior, health inequality, sociology of health.

1. Introduction

Healthcare is an intrinsic human need, but it is still most deeply stratified by social class and other aspects of society based stratification. Despite advances in healthcare policies and medical technologies for universal access to healthcare, inequality persists in how various social classes approach and use healthcare. This essay analyzes the intricate dynamics of social class and healthcare-seeking behavior using sociological theories.

Disease and health are not just biological states but are deeply situated within the social organization and cultural contexts in which individuals reside. One of the most powerful social determinants of health conditions and behavior is social class, defined as hierarchical distinction in society based on availability of economic resources, occupational status, education, and power. Individual's health-seeking behavior as choices and In fact, despite advances in medicine and policy efforts toward universal access, inequalities persist in how different social classes seek and obtain healthcare.

This paper analyzes the intricate interplay between social class and health-seeking patterns. Health and illness are not merely biological states; they are deeply entrenched in the social and cultural environments where people live. Social class is perhaps the most significant of the social determinants that shape health outcomes and behavior, and it denotes hierarchical stratification in society based on access to economic resources, occupational status, education, and power.

The health-seeking behavior of people characterized as decisions and actions in relation to health need is not the same in social groups. Studies repeatedly demonstrate that position in class affects not just access to health care services, but also definitions of illness, use of formal as opposed to

informal care, confidence in medical institutions, and timing of seeking care (Cockerham, 2017; Mechanic, 1962). Individuals in the middle and upper classes typically possess greater resources, health awareness, and cultural capital that enable them to better utilize healthcare systems. In contrast, the working class and economically disadvantaged groups tend to confront structural barriers such as cost, distance, bureaucratic challenges, and discriminatory treatment that limit their healthcare options (Marmot, 2005; Navarro, 2004). Social class is a central category for social determinants of health-disease research in view of the fact that health hazards will congregate at varying rates based on social class and position in the social structure. The higher the class position in the social hierarchy, the more likely that class members will have longer and healthier lives. Conversely, socially disadvantaged groups within the social structure have an unequal share of injuries, illnesses, and death relative to more privileged groups (Barata et.al. 2013)

The study is based on both classic and contemporary sociological concepts like Marx's concept of class conflict and resource control and Weber's concept of stratification per se. It employs Pierre Bourdieu's concept of habitus and capital as well. Bourdieu's formulation is particularly relevant, as it makes it possible to comprehend how class-based dispositions, based on experiences, influence how people understand illness and make decisions relating to health. Bourdieu (1984) supplemented the theory of class with cultural, social, and symbolic capital. According to him, social connections and cultural skills affect healthcare-seeking behavior in addition to money. For instance, individuals with greater cultural capital would be more likely to navigate complicated healthcare systems or speak up for themselves. They may also be more inclined to question medical recommendations and obtain preventative treatment, while others who have less in terms of money would accept deterioration in health as the norm. By shaping lifestyles, health literacy, and ability to negotiate healthcare systems, class-based resources also affect health behaviours and outcomes, as theorized by Bourdieu's (1984) theory of capital—economic, cultural, and social. Bourdieu argued an inherent and necessary link between class position and habitus, i.e., a collection of socially derived provisions that the agents internalize as a consequence of experience of belonging to a particular class. The interconnection of habitus and day-to-day practices shapes lifestyles that, in turn, compose social collectives or status groups that are distinguished by the symbolic boundaries of the various positions in the class structure held by the agents. On the basis of agents' positions in the social space, classes can be drawn, i.e., collections of agents with a similar position and who, under similar material constraint, will have similar interests, attitudes, and social practices.

Social classes are distinguished from each other on the basis of how they stand in relation to the means of production, under Karl Marx's conflict theory. While selling their labour, the workers (proletariat) are subject to the control of the resources by the owners (bourgeoisie). In this perspective, health is a commodity that comes under the influence of the relations of capitalist production. Marxist theorists propose that capitalism sustains inequalities in health since the working class has no control over working conditions, endure occupational risks, and have poor access to good healthcare (Navarro, 2004).

Weber (1978) emphasized the issue of "life chances," which refers to the possibility individuals have to enhance their well-being in life. People in higher socioeconomic statuses usually have better life opportunities, including nice accommodations, healthy nutrition, and medical services. In countries like India, wherein healthcare infrastructure is highly unequal and stratified, this research also examines the intersection of class with other social categories like caste, gender, and rural-urban differences (Qadeer, 2011; Baru, 2005). Through the commodification of health and shifting responsibility from the state to the individual, the health political economy—specifically under neoliberal systems—has exacerbated gaps (Misra, 2020). This study therefore, sets the stage for an in-depth examination of the ways in which class structures shape health behaviour by theorizing healthcare-seeking as a socially embedded practice. It resists the normative assumptions of choice and rationality within public health models and argues the need for a relational and structural understanding of health behaviour based on sociological research.

I. Class and Health Outcomes

Lower socioeconomic groups have poorer health outcomes, as shown through empirical studies. In line with Marmot et al., the health outcomes become poorer as one goes down the social hierarchy. Even in countries that have universal healthcare, this gradient exists, implying that some socioeconomic determinants beyond insurance coverage affect health (Marmot et al. 1662). One of the primary determinants of health outcomes, social status plays an important role in shaping morbidity and mortality patterns in most societies. Individuals within lower socioeconomic groups have poorer health outcomes compared to individuals in higher socioeconomic groups, with a repeated gradient reported by many studies (Marmot, 2005; Adler & Ostrove, 1999).

This relationship takes into account the collective effect of social, psychological, and environmental factors together with material resource differences. Health problems encompass hazardous job conditions, poor housing quality, restricted access to proper food, and excessive chronic stress are frequently more prevalent in lower socioeconomic groups (Wilkinson & Marmot, 2003). These, according to Kawaki, Adler, and Dow (2010), produce more mental disorders, respiratory disease, diabetes, and cardiovascular disease among deprived groups. Marmot (2005) points out, for instance, that chronic stress tied to a lower social rank initiates physiological mechanisms that can result in systemic inflammation and defective immunological function, making it more susceptible to disease.

Furthermore, access to healthcare is one of the social determinants of health that go beyond proximal material circumstances. For timely diagnosis and treatment, working-class individuals face challenges such as cost, no insurance, transport, and discrimination at health centres (Braveman & Gottlieb, 2014). In marginalized populations, these structural injustices prolong the cycle of poor health and amplify health inequities. Sociological theoretical analysis explains more about these trends. For example, according to Link and Phelan's (1995) theory of fundamental causes, class is a "fundamental cause" of differences in health because it reflects access to flexible resources like money, knowledge, and social contacts that can be used to avoid the consequences of disease or prevent risk of disease. Overall, the evidence is such that social

class and health are closely linked by a complex interplay of behavioural, psychological, and structural factors. It therefore follows that addressing the general social and economic inequalities causing ill health is every bit as important as extending healthcare access.

II. Health Literacy and Navigational Capacity Health literacy

Having access to, analyzing, and comprehending health information, is also affected by class. People with higher socioeconomic status are more likely to have the health literacy to follow treatment schedules, make healthy decisions, and participate in preventive care. People's patterns of seeking healthcare and health outcomes are greatly influenced by their health literacy, which can be understood as the capacity to access, process, and comprehend the underlying health information and services required to make healthy health decisions (Nutbeam, 2008). It is known that social classes differ in health literacy levels, with lower socioeconomic statuses tending to have lower health literacy, thus diminishing their ability to interact with healthcare systems effectively (Berkman et al., 2011). Improved health literacy allows individuals to comprehend medical information, navigate difficult healthcare environments, and advocate for themselves. Improved navigation skill is responsible for better adherence to treatment plans, timely seeking of care, and enhanced contact with health professionals (Squiers et al., 2012). Low health literacy in disadvantaged populations, on the contrary, increases health disparities by leading to misdiagnosis confusion, improper use of prescriptions, and delayed or avoided care (Berkman et al., 2011; Pleasant, 2014).

Sociological accounts illuminate more clearly the interplay between social class and health literacy. Since health literacy constitutes a form of embodied cultural capital that enables individuals to decipher medical vocabulary and institutional routine, Bourdieu's (1984) theory of cultural capital is particularly relevant now. Middle-class and upper-class patients are more capable of negotiating healthcare systems due to this cultural competence than working-class patients, who may not have enjoyed equal exposure to such information and skills (Schillinger et al., 2002).

In addition, the concept of "navigational capacity" is more than individual literacy; it is also the resources and social networks by which it is easier to communicate with hospitals. Social networks, provider trust, and knowledge of healthcare procedures affect effective access to care (Freeman et al., 2018). To receive timely and proper care, populations whose navigational capacity is less often find themselves facing bureaucratic barriers, discrimination, and fragmented services (Gonzalez et al., 2015). Decreasing health inequities involves closing gaps in navigational capacity and health literacy. Marginalized groups' access to healthcare can be enhanced through interventions like patient navigation programs, culturally competent education, easier health communication, and system changes (Institute of Medicine, 2015).

III. Cultural Beliefs and Health-Seeking Behavior

Health beliefs and behaviors are significantly determined by culture. Zola and Helman propose that working-class individuals can defer seeking medical care due to fatalism regarding illness or since they rely on unofficial support structures. Distrust of official structures and structural marginalization often function to consolidate these beliefs (Zola,1973). The way people perceive

illness, assess symptoms, and make decisions about the best possible care for them depends highly on their beliefs regarding culture. These concepts contribute a lot to health-seeking behavior as they influence not only what is perceived to cause disease but also what types of therapies and types of practitioners to see (Helman, 2007). Cultural models that set standards for recovery, pain, and the role of medical professionals are embedded in health decisions and practices. Cultural models can benefit or harm individuals' capability to engage with formal healthcare institutions, as indicated by studies. For example, some ethnicities might value traditional therapeutic methods such as herbal therapy, religious rituals, or consultations with indigenous healers more; they often view biomedical treatment as an additional or final option (Kleinman, 1980; Pescosolido et al., 2008). These approaches, which emphasize social harmony and balance more than mere biological matters, are often founded on holistic beliefs about health. In addition, social standing, power dynamics, and cultural perceptions all overlap to determine access to health. As a result of discrimination or cultural disparity, marginalized groups will often experience distrust of formal health institutions, which further impacts the way they access medical care (Smedley, Stith, & Nelson, 2003).

Symbolic interactionism is a sociological theory that explains how individuals make sense of and negotiate cultural meanings of health and illness. Individuals construct meanings from social interactions that affect their choices about where and when to obtain medical care (Blumer, 1969). In addition, based on Bourdieu's habitus theory, dispositions of culture formed through early socialisation affect health behaviors and susceptibility to certain forms of medical knowledge (Bourdieu, 1984). Culturally sensitive health interventions and improved patient-provider communication necessitate an understanding of the power of cultural beliefs. To enhance trust and compliance, culturally competent care considers patients' beliefs and acknowledges multiple health worldviews (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). In conclusion, cultural beliefs provide a very important perspective on health-seeking behavior, signaling the importance of integrating sociocultural sensitivity to the delivery of healthcare in order to reduce inequities and improve outcomes.

IV. Intersectionality: Gender, Race, and Class

The convergence of class with other identities such as gender and race worsens inequalities. Crenshaw and Schulz et al. observe that women and racial minorities in lower social strata experience augmented impediments to care, such as discriminatory policies and medical culture incompetence. The theory of intersectionality, introduced by Kimberlé Crenshaw (1989), offers a critical lens through which the ways in which different social identities intersect to create distinct experiences of marginalization, especially in health settings, can be understood. Intersectionality holds that people are located in interlocking systems of domination, such as race, class, gender, and sexuality. These identity axes are not discrete; rather, they exist synergistically to influence health-seeking behavior and access to healthcare. Studies in public health and medical sociology have increasingly come to acknowledge that healthcare disparities cannot be explained fully using single-axis analyses. African American women from the lower class, for instance, face barriers to healthcare that are not additive effects of racism, classism, and sexism but rather a

specific type of disadvantage (Schulz et al., 2002). Such populations are more likely to forgo care, receive dismissive or discriminatory care, and have no access to culturally competent services (Williams & Mohammed, 2009). Gender roles also play a role in healthcare-seeking behaviors. Women from lower socio-economic backgrounds, in particular, tend to put their families' health needs ahead of their own, a phenomenon influenced by gendered norms and economic realities (Read & Gorman, 2010). In addition, men from racial and economic minorities might forego seeking healthcare due to cultural norms of masculinity and perceived systemic bias in medical facilities (Griffith et al., 2011).

This intersectional framework highlights the importance of understanding that public health interventions and healthcare policy need to take into consideration the multi-faceted realities of populations at the intersection of multiple marginalized identities. Doing otherwise can lead to efforts that neglect the underlying causes of disparities and do not extend to the most vulnerable populations.

Conclusion

This paper has shown that health-seeking behavior is highly conditioned by social class. From theoretical understanding and empirical findings, it is clear that economic, cultural, and social capitals condition people's health behaviors and conditions. Reduction of health disparities involves addressing the structural causes of inequality. Future research needs to be directed toward longitudinal studies in which to track how changes in class status affect health behaviors over time, as well as intervention-based studies to evaluate interventions aimed at counteracting class-based differences.

References

Adler, N. E., & Ostrove, J. M. (1999). Socioeconomic status and health: What we know and what we don't. *Annals of the New York Academy of Sciences*, *896*(1), 3–15.

Bourdieu, P. (1984). *Distinction: A social critique of the judgement of taste* (R. Nice, Trans.). Harvard University Press.

Bourdieu, Pierre. "The Forms of Capital." *Handbook of Theory and Research for the Sociology of Education*, edited by John G. Richardson, Greenwood, 1986, pp. 241-258.

Braveman, P., & Gottlieb, L. (2014). The social determinants of health: It's time to consider the causes of the causes. *Public Health Reports*, *129*(Suppl 2), 19–31.

Cockerham, W. C. (2017). *Medical sociology* (14th ed.). Routledge.

Crenshaw, Kimberlé. "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique." *University of Chicago Legal Forum*, vol. 1989, no. 1, 1989, article 8.

Dixon-Woods, Mary, et al. *Vulnerable Groups and Access to Health Care: A Critical Interpretive Review*. National Co-ordinating Centre for NHS Service Delivery and Organisation, 2006.

Freeman, H. P., Rodriguez, R. L., & Freeman, S. F. (2018). The history, principles, and future of patient navigation: Commentary. *Seminars in Oncology Nursing*, *34*(2), 148–151.

Gonzalez, H. M., Tarraf, W., Whitfield, K. E., & Vega, W. A. (2015). The role of health literacy in the racial and ethnic disparities in health and health care. *Health Affairs*, *34*(10), 1755–1762.

Griffith, D. M., Ellis, K. R., & Allen, J. O. (2011). How does health happen? A sociological perspective on the social determinants of health. *American Journal of Men's Health, 5*(6), 528–534.

Gulliford, Martin, et al. "What Does 'Access to Health Care' Mean?" *Journal of Health Services Research & Policy*, vol. 7, no. 3, 2002, pp. 186–188.

Helman, Cecil G. *Culture, Health and Illness*. Hodder Arnold, 2007.

Institute of Medicine. (2015). *Health literacy: Improving health, health systems, and health policy around the world*. The National Academies Press.

Kleinman, A. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry*. University of California Press.

Kawachi, I., Adler, N. E., & Dow, W. H. (2010). Money, schooling, and health: Mechanisms and causal evidence. *Annals of the New York Academy of Sciences*, *1186*(1), 56–68.

Link, B. G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior*, *35*, 80–94.

Marmot, Michael, et al. "Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health." *The Lancet*, vol. 372, no. 9650, 2008, pp. 1661–1669.

Marmot, M. (2005). *The status syndrome: How social standing affects our health and longevity*. Times Books.

Mechanic, D. (1962). *The concept of illness behavior*. Journal of Chronic Diseases, 15(2), 189–194.

Navarro, V. (2004). The political economy of social inequalities: Consequences for health and quality of life. *International Journal of Health Services*, 34(1), 87–107.

Navarro, Vicente. "What We Mean by Social Determinants of Health." *International Journal of Health Services*, vol. 39, no. 3, 2009, pp. 423–441.

Nutbeam, D. (2008). The evolving concept of health literacy. *Social Science & Medicine*, *67*(12), 2072–2078.

Paasche-Orlow, Michael K., and Michael S. Wolf. "The Causal Pathways Linking Health Literacy to Health Outcomes." *American Journal of Health Behavior*, vol. 31, suppl. 1, 2007, pp. 19–26.

Pleasant, A. (2014). Advancing health literacy measurement: A pathway to better health and health system performance. *Journal of Health Communication*, pp. 148–157.

Read, J. G., & Gorman, B. K. (2010). Gender and health inequality. *Annual Review of Sociology, 36*, 371–386.

Schillinger, D., Bindman, A., Wang, F., Stewart, A., & Piette, J. (2002). Functional health literacy and the quality of physician-patient communication among diabetes patients. *Patient Education and Counseling*, *52*(3), 315–323.

Schulz, Amy J., et al. "Social Context, Stressors, and Disparities in Women's Health." *Health Education & Behavior*, vol. 29, no. 3, 2002, pp. 312–321.

Smedley, Brian D., et al. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. National Academies Press, 2003.

Squiers, L., Peinado, S., Berkman, N., Boudewyns, V., & McCormack, L. (2012). The state of the science of health literacy measurement. *Studies in Health Technology and Informatics*, *180*, 17–33.

Weber, M. (1978). *Economy and society: An outline of interpretive sociology* (G. Roth & C. Wittich, Eds.). University of California Press

Williams, D. R., & Mohammed, S. A. (2009). Discrimination and racial disparities in health: Evidence and needed research. *Journal of Behavioral Medicine, 32*(1), 20–47.

Wilkinson, R. G., & Marmot, M. (Eds.). (2003). *Social determinants of health: The solid facts* (2nd ed.). World Health Organization.

Zola, Irving Kenneth. "Pathways to the Doctor: From Person to Patient." *Social Science & Medicine*, vol. 7, no. 9, 1973, pp. 677–689.