Use of Socioeconomic Status Scales in Medicine and Public Health

Dear Editor,

This is in reference to an article entitled "a critical appraisal of Kuppuswamy's socioeconomic status (SES) scale in the present scenario" published in J Fam Med Primary care (2014;3:3-4).[1] The authors deserve credit for touching on an important topic in public health. SES is commonly identified as the social standing or class of an individual or group. It is often measured as a combination of education, income and occupation and expressed as an index as for example in Kuppuswamy's scale. It has its use in not just social science, but also in medicine. In medicine and more so in public health/population medicine, examinations of SES often reveal inequities in access to health care resources. It also reveals a pattern to the health problems existing in a specific population. There are many unanswered questions while using Kuppuswamy's scale for assessment of SES in general and the authors have dealt with them in substantial measures.

However, my concern with regard to this scale is regarding its use in medicine and public health.

The two key areas that assessment of SES used to address where (1) a probable disease pattern with low SES population presenting more commonly with nutritional deficiency and communicable diseases and high SES showing more of obesity and noncommunicable diseases; (2) access to healthcare with high SES showing a better access.

According to WHO, there is now evidence that the poorest in developing countries face a triple burden of communicable disease, noncommunicable disease and sociobehavioral illness. The global burden of disease methodology shows that the epidemiological transition is already well advanced, suggesting that public health policy in poor countries, with its traditional emphasis on infectious disease, will need to adapt.[2] Keeping this in view a pattern of diseases expected on the basis of SES seems to lose value with the changing health scenario.

This takes me to the second point of my discussion. What seems to work the most in favor of better access is; availability and geography probably plays the key role in that. I end my point with a simple question; does access to healthcare differ between a well to do businessman, not highly educated (and therefore of low SES) located near a hospital differ from a teacher with a postgraduate qualification residing (relatively higher SES) in the same area? The answer to this question will make us look for better alternatives to SES.

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