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The Nexus between Health-Oriented Lifestyle, Social Inequality, Access to Health Services, and Dimensions of Social Health among Sari Citizens

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Abstract

Social health is one of the main pillars of human health that critically contributes to maintaining balance in the social life of any individual so that its full reflection can ensure social growth in any community. This study explored the nexus between health-oriented lifestyle, social inequality, access to health services, and dimensions of social health among Sari citizens (Mazandaran province, Iran). The extant study was conducted using a survey method and questionnaire. A survey study targeted 125400 citizens between the age of 15 and 60 years living in Sari, of which 380 were eventually selected as the sample size considering Cochran's formula and through the cluster sampling method. Research findings indicated a positive and direct association between access to health services and dimensions of social health. There was also a positive and direct connection between the health-oriented lifestyle and dimensions of social health.

On the other hand, there was a negative and significant nexus between social inequality and social health. Therefore, the higher the social inequality, the lower the social health rate. The diminished rate of social inequalities improves the health level of citizens. A total of 46.3% of variations in social health were explained, according to the multivariate regression results. Access to health services and social inequality had the greatest impact on social life, while the health-oriented lifestyle exhibited the least impact on social health as the dependent variable.

Keywords: Social Health, Lifestyle, Social Inequality, Access to Health Services

INTRODUCTION

Today, social health has become a crucial and sensitive issue. Social health reflects social status and stems from various social factors. Moreover, communities consider trusting a vital case in the current era. Policymakers introduce health as their priority, so equal health distribution is their main concern. The notion of justice is targeted in health policies. The international framework of human rights emphasizes moving toward health justice and equality by consideration of health's social factors. Health is a sophisticated phenomenon that can be investigated through different approaches. There are two approaches to health concept over recent decades: the medical approach that is based on health technology and intervention, and another approach that considers health as a social phenomenon (Zaboli & Sanaeinasab, 2014: 7). According to the health definition provided by Switzer et al., health is a notion affected by various economic, social, cultural, mental, biological, religious, and environmental determinants. Therefore, medical practitioners and social scientists, especially sociologists and psychologists, are interested in health (Alizadeh, 2013: 184).

In addition to other developed dimensions of society, social health is an important factor for the social development of cultural society within a permanent and continuous process. Therefore, social health should be institutionalized in Iranian society with special cultural, social, normative, and ethical conditions. The absence of social health causes societal collapse resulting in social and cultural harm with extreme social capital decline, insecurity, and mistrust. The mentioned consequences will destroy society. Social health has recently entered the sociology literature reflecting how a person evaluates the community, quality, and quantity of involvement in the community. Social health can be an important factor in accepting social norms and also plays a vital role in reducing evasion of law and social disorders because it is associated with individuals' sociability in society. On the other hand, there is higher social participation in a society where its people have social health. Social health can also influence the performance of social institutes responsible for providing social security (Samaram, 2009: 11).

Social health plays a vital role in ensuring the dynamism and efficiency of every society. Accurate and comprehensive planning is necessary to provide social health for all 25-55 years old citizens living in Sari, Iran, because social heath is markedly influential in all personal, familial, and social functions. Health is a significant factor and a basic right to life. Health is indeed an ability that makes human life valuable. In other words, health is wealth, and the qualitative characteristics of humans are their assets because these characteristics can create productivity, higher output, income, and welfare. We can improve labor quality by boosting labor's health level. Proper health levels will increase labor's potential and actual power, enhancing their ability to acquire better skills and jobs (Amin Rashti & Asghari, 2011: 136). Many effective factors affect health levels with different contributions, including service system (25%), genetical and biological factors (15%), physical, environmental, behavioral factors (10%), and social factors (50%) (Marandi, 2006: 2044). Accordingly, the sociological study of social health in Sari Province, Iran, is necessary.

Literature Review

Social Health

Social health in life indeed refers to all positive and negative evaluations and attitudes of people towards other people with whom they socially interact in their daily lives. A socially healthy person can do their social activities and roles normally and create a link to society and social norms. Social health includes social skill levels, social functioning, and the ability to recognize self as a member of a larger community. From this point of view, every family member is a member of a society considering all individuals' socioeconomic status and welfare concerning the social network (Sajadi & Sadr Al-Sadat, 2005: 246).

“A person with social health performs with full adaptation with existing conditions. This is a kind of adaptation in which the balancing process is not conflicting but is full of agreement. It is a network of friends in which they feel comfortable and can fulfill their social responsibilities" (Hezarjaribi & Mehri, 2012: 50). In the opinion of Keyes, "social health is evaluating status and productivity of a person in the society" that reflects "positive social health" (Keyes,1998: 122) indicating that social health represents individuals' perception of their experiences in the social environment. Social health is a subcomponent of the health concept that means the ability to play social roles without any objective or subjective intention to harm others (Keyes, 2004).

Keyes defines social health as how a person evaluates and perceives their performance in the community and the quality of their relationships with others, relatives, and social groups in which they have a membership. Keyes introduces a five-factor model following this principle. This model comprises five factors of social coherence, acceptance, actualization, contribution, and integration that are health indicators (Hatami, 2010). Keyes introduced five dimensions of social health are just one part of social health indicators (positive-individual continuum). In this step, social health dimensions consist of social skill levels, social performance, and the ability to perceive the self as a member of a larger society (Kangarloo, 2008: 4).

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Lifestyle

Lifestyle refers to a person's behaviors to meet their needs. In this case, the person chooses a specific narrative for their identity, making them distinguished from others (Rahmat Abadi & Aghabakhshi, 2006: 20). Health-oriented lifestyle entails various behavioral patterns and personal habits throughout life, including diet, movement, behavioral habits, etc. that emerge in socialization process (Park, 2004). Lifestyle is an integrated pattern of individual and collective behaviors that appear symbolically in a certain life area. Lifestyle is shaped based on the consumption, ethical, value, and aesthetical principles, or various external factors, including age, revenue, gender, and or geography, requiring to select of various elements existing in the new and modern world (Weber, 2013: 18).

Many Iranian researchers have studied lifestyle dimensions considering Bourdieu's theory and his empirical study. This study selected some indicators associated with the objective and external actions of individuals and the life of Sari citizens based on Bourdieu's theory and social research field. The selected components included four indicators: cultural consumption, shopping pattern, leisure activities, and body management.

Cultural consumption: lifestyle indicators have been derived from cultural consumption for two reasons. First, cultural consumption does not require high costs compared to other activities, and people have a lot of cultural consumption choices. Moreover, an initiative that is an element constituting lifestyle appears in activities and cultural consumption. Second, many researchers have retested Bourdieu's theory about high classes of society that distinguish themselves from others using sublime culture. However, people's choices in cultural consumption, leisure activities, and consumption patterns are the main indicators used in lifestyle studies. Cultural consumption includes using some cultural products, such as journals, newspapers, internet, satellite, etc., enrolling in training courses (language, computer, entrance exam, etc.), membership, and use of cultural environments (e.g., cultural center, cinema, library, etc.), and art activities, such as playing music, calligraphy, and painting (Tanhaei, 2011: 244).

Leisure Activities: leisure activities are actions people do in their free time. People select leisure activities based on their cultural values and initiatives. Cultural consumption is normally a subset of leisure activities, while all activities are not considered cultural consumption. Like cultural consumption, leisure activities have different dimensions and forms.

Shopping pattern: how and what product people buy indicates their lifestyles. This can be an effective index for various products available to most people (Rahmat Abadi, 2006: 246).

Body Management: body management means continuous control and manipulation of the appearance and visible characteristics of the body (Karami Ghahi, 2013: 91).

Social Inequality

Inequality is defined as the differences between individuals or socially determined positions occupied by them that influence the life (salaries, opportunities, rewards, and rewards) of the person (Grabb, 2002: 10). Social inequality is a status in which individuals, families, and groups of the society have different accesses to opportunities and situations existing in the structural structure. Inequality means unequal access of individuals to four valuable economic, social, political, and cultural resources (Chalabi, 2010).

Access to Healthcare Services

Access to healthcare services reflects the appropriateness of some factors, including the ability to play cost, availability, accessibility, acceptability, and services-needs adaptation.

Research Background

Sharbatiyan and Tavafi (2015) carried out a study entitled “a sociological survey of subjective evaluation of social health indicators in the youth (case study: youth of Ghaen city in south Khorasan).” The results showed the average social heath of the youth living in this city and social integration and social contribution obtained the highest and lowest rank, respectively, among dimensions of social health. The results also indicated a significant association between demographic variables (age and socioeconomic status) and dependent variable (social health).

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Moreover, there was a significant difference between marital status and social health, while there was no significant relationship between gender and social health.

Zahedi Asl et al. (2016) conducted a study entitled "social factors influencing social health of the elderly in Kouhdasht." According to the results, the majority of respondents had moderate social health. In addition, there was a direct and significant association between social status, social support, communicational skills, and social health, while there was no significant correlation between leisure time and social health.

Yazdan Panah (2003) carried out a study entitled "the relationship between social factors and social health of students studying at Shaheed Bahonar University" and found a significant association between social health, independent variables (e.g., social trust, social contribution, access to facilities and environmental services, and person' evaluation of their social class and family), and contextual variables (e.g., marital status, job status, birthplace, and academic discipline).

Hezarjaribi and Mehri (2012) conducted a study entitled "Analysis of the nexus between social capital and mental-social health." They found a significant correlation between the social contribution dimension of social capital and social-mental health, including relationships with friends, relatives, and family, social trust, neighborhood relationships, social integration, the tendency towards others, sacrifice for strangers, and social support, and interest in society. Moreover, there was a significant relationship between social capital, social health, and mental health.

Chandola et al. (2007) carried out a study entitled "social inequalities in self-reported health in early old age" to describe differences in trajectories of self-reported in an aging cohort according to occupational grade. This study was done on official employees in Britain from 1985-2004. Participants comprised 10308 men and women aged 35-55, employed in 20 London civil service departments. The results showed that social inequality in self-reported health increased early. Individuals from lower occupational grades had a worse situation in terms of physical health compared with people that had higher grades. This widening gap revealed that health inequalities could become a public health issue, especially in the aged population.

Blanco and Diaz (2007) conducted a study entitled "social order and mental health: a social wellbeing approach" to address the relationship between dimensions of social health as a social order index with other aspects of health, including depression, self-esteem, perceived health, deprivation, anomy and social interactions, negative and positive affections, and satisfaction.

Research Method

This was applied research in terms of objective and a survey study in terms of method. The required data were collected through a questionnaire. First, the preliminary questionnaire was designed and pretested, and then the final questionnaire was developed. In the next step, professional questioners were employed to meet citizens in the sample population and fill out questionnaires using the face-to-face interview technique. The collected data were analyzed through SPSS software and descriptive tables. Therefore, two bibliographic (library) and field (survey and interview) methods were used for data collecting.

All Sari citizens aged 15-60 were selected as the statistical population of this study. According to the census conducted in 2016, there were 125400 citizens (15-60 years old) living in Sari Province, Iran. The sample size equaled 384 using the Cochrane formula. The sampling method was based on the random cluster method in municipal regions of Sari Province (e.g., Sari, Kiasar, Farah Abad, and Frim). Accordingly, samples were randomly selected from four cities in the province then questionnaires were distributed among them. Validity was ensured using the face validity method and confirmation given by guidance and advisor professors. Cronbach's alpha was used to achieve reliability. In this way, questionnaires were distributed among Sari citizens. The results of this assessment led to some revisions in the questionnaire. Table 1 reports the Cronbach's alpha coefficient of studied variables (Table 1).

Table 1. Cronbach's alpha coefficients for research indicators

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Variable	Items (N)	Cronbach's alpha coefficient
Access to healthcare services	6	0.806
Social inequality	6	0.812
Lifestyle	51	0.735
Cultural consumption	14	0.708
Body management	11	0.721
Leisure activities	18	0.739
Shopping pattern	8	0.810
Social health	32	0.960
Social integration	7	0.840
Social acceptance	6	0.847
Social contribution	6	0.945
Social actualization	7	0.845
Social coherence	6	0.792

Research Hypotheses

Hypothesis 1: seemingly, there is a significant association between social inequalities and the social health of Sari citizens.

Hypothesis 2: seemingly, there is a significant association between the health-oriented lifestyle of Sari citizens and dimensions of health.

Hypothesis 3: There is a significant association between access to health services and dimensions of health.

Findings

The results indicated that about 65% of samples were men with a higher frequency than 35% (n=140) women. Around 21.5% were younger than 40-44 and had the highest frequency. Around 57% of the samples were married, while 41% were single.

The activity status of respondents was another contextual variable considered in this study. Regarding respondents' activity, 56.5% are employed, 95% are unemployed, 19.3% are housekeepers, 12.3% are students, and around 2.5% are active in other areas. In this study, most respondents (138 members) (34.5%) had BA degrees. Fathers of the highest frequency of 107 respondents (26.8%) had a diploma. Regarding mothers' education level, the highest frequency equaled 89 respondents (22.3%) whose mothers had elementary education levels.

According to research findings, most studied respondents (32%) earned 3-4 million Toman monthly. Most respondents (29%) had to spend 3-4 million Toman monthly. Findings indicated that most studied respondents (34.8%) had average social class. Regarding housing situation, most of the respondents (54.8%) had a personal house.

As reported in Table 2, there is a negative and significant relationship between social inequality and social health. The higher the social inequality, the lower the social health will be. Therefore, lower social inequalities can improve the health level of citizens. The Pearson correlation coefficient between social inequality and social health equaled -0.512 at the significance level of 0.

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Table 2. Coefficient of Pearson correlation between social inequalities and social health

Variables	Social health	Social integration	Social acceptance	Social contribution	Social actualization	Social coherence	Economic inequality	Political inequality	Social inequality	Cultural inequality	Social inequality scale
Social health	1	0.788**	0.908**	0.943**	0.862**	0.879**	0.040	0.067**	0.773**	0.202**	0.512**
Social integration		1	0.724**	0.689**	0.441**	0.609**	0.026	0.087	0.741**	0.572**	0.623**
Social acceptance			1	0.838**	0.705**	0.722**	-0.008	0.030	0.606*	0.102*	0.357**
Social contribution				1	0.813**	0.765**	0.061	0.078	0.684**	0.139**	0.455**
Social actualization					1	0.794**	0.053	0.057	0.580**	-0.101*	0.307**
Social coherence						1	0.035	0.031	0.803**	0.196**	0.512**
Economic inequality							1	0.431**	0.048	0.069	0.608**
Political inequality								1	0.093	0.065	0.551**
Social inequality									1	0.381**	0.703**

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Cultural inequality										1	0.597**
Social inequality scale											1

**. Correlation is significant at the 0.01 level
*. Correlation is significant at the 0.05 level

Table 3. Coefficient of Pearson correlation between lifestyle and dimensions of social health

Variables	Social health	Social integration	Social acceptance	Social contribution	Social actualization	Social coherence	Cultural consumption	Body management	Leisure activities	Shopping pattern	Lifestyle
Social health	1	0.788**	0.908**	0.943**	0.862**	0.879**	0.629**	0.018	0.272**	0.535**	0.477**
Social integration		1	0.724**	0.689**	0.441**	0.609**	0.709**	0.355**	0.458**	0.646**	0.710**
Social acceptance			1	0.838**	0.705**	0.722**	0.488**	-0.124*	0.134**	0.495**	0.325**
Social contribution				1	0.813**	0.765**	0.573**	-0.042	0.265**	0.470**	0.415**
Social actualization					1	0.794**	0.353**	-0.192**	0.140**	0.348**	0.210**
Social coherence						1	0.661**	0.108*	0.178**	0.383**	0.445**
Cultural consumption							1	0.367**	0.445**	0.518**	0.776**
Body management								1	0.596**	0.174**	0.704**

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Leisure activities									1	0.620**	0.854**
Shopping pattern										1	0.436**
Lifestyle											1

**. Correlation is significant at the 0.01 level
*. Correlation is significant at the 0.05 level

According to Table 3, this hypothesis was confirmed based on the correlation coefficient of 0.477 in the positive direction at the confidence level of >99% and the error level of <1%. In other words, there is a direct and significant correlation between lifestyle and social health. A direct, positive, and significant relationship exists between social health dimensions and lifestyle. Moreover, there is a positive and significant association between lifestyle dimensions (except for body management) and social health. For instance, the Pearson correlation coefficient between cultural consumption and social health equaled 0.629 at the significance level of 0. The higher the cultural consumption, the higher the social health rate and vice versa.

Table 4. Coefficient of Pearson correlation between access to health services and dimensions of social health

Dependent variable	Person correlation coefficient	Sig.	Correlation result
Social health	0.590**	0.000	The positive and significant correlation
Social integration	0.445**	0.000	The positive and significant correlation
Social acceptance	0.524**	0.000	The positive and significant correlation
Social contribution	0.652**	0.000	The positive and significant correlation
Social actualization	0.494**	0.000	The positive and significant correlation
Social coherence	0.442**	0.000	The positive and significant correlation

**. Correlation is significant at the 0.01 level
*. Correlation is significant at the 0.05 level

According to results reported in Table 4, the association between variables indicates a significant correlation between two variables. Therefore, a positive and direct association exists between access to health services and health dimensions. Hence, the more access to health services, the more the social health rate will be, and vice versa. This positive correlation is significant, with a probability greater than 99%. The Pearson correlation coefficient between access to health services and social health equaled 0.590 at the significance level of 0. Since the

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significance level is less than 5% for the correlation coefficient, there is a significant association between access to health services and social health. There is also a significant and positive correlation between access to health services and dimensions of social health. In other words, high access to health services in society improves social health and its dimensions.

Table 5. Regression coefficients of social health

Variables	Regression coefficients		t-test		Collinearity test	
	B	Beta	T	Sig	Tolerance	VIF
Constant value	9.611		1.122	0.263		
Lifestyle	-0.025	-0.021	-0.364	0.716	0.426	2.348
Access to health services	2.342	0.482	10.545	0.000	0.652	1.534
Social inequality	0.703	0.308	6.003	0.000	0.519	1.925

Table 5 depicts the regression coefficients of variables. In this table, regression coefficients of all main variables' impacts (Beta), except for lifestyle, are significant. Access to health services and social inequalities had the highest beta values among significant variables. Regression coefficients indicate that access to health services and social inequality are significant at a level greater than 99%. A one-unit change in access to health services will lead to around 0.482 variations in the social health rate. According to constrain and B values of variables, the multiple regression equation of the present study is designed as follows:

$$Y = a + bx_1 + bx_2 + \cdots . bx_n + ei$$

Social health= 9.611 + 0.482 (access to health services) + 0.308 (social inequality) + ei

Table 6. Direct and indirect effects of variables on social health

Variable	Direct effect	Indirect effect	Toral effects
Lifestyle	-0.02	0.25	0.23
Access to health services	0.48	0	0.48
Social inequality	0.31	0.17	0.48

Table 6 shows direct, indirect, and total effects on the lifestyle equaled -0.02, 0.25, and 0.23, respectively. Direct, indirect, and total effects on access to health services equaled 0.48, 0, and 0.48, respectively. Direct, indirect, and total effects on social inequality equaled 0.31, 0.17, and 0.48, respectively. Therefore, access to health services and social inequality had the highest effects. Compared to access to health services and social inequality, lifestyle had a lower effect on the dependent variables of social health.

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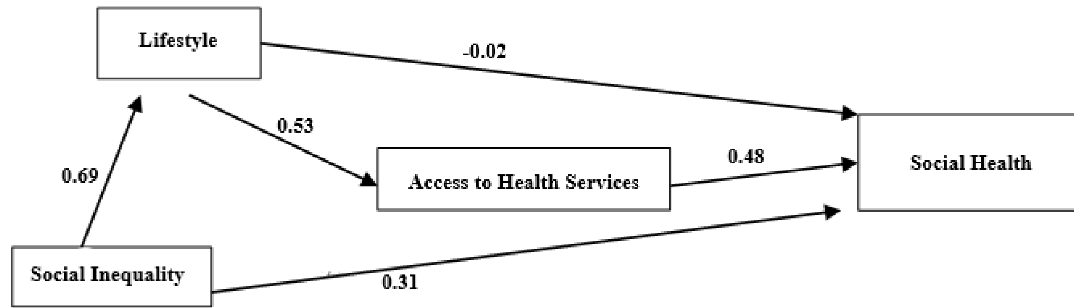

Figure 1. Nexus between variables

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Conclusion

The study examines the nexus between a health-oriented lifestyle, social inequality, access to health services among Sari citizens, and dimensions of social health. There is a significant association between social inequalities and the social health of Sari citizens. There is a negative and significant relationship between social inequality and social health. Therefore, the higher the social inequality, the lower the social health will be. Reduces social inequalities and improves the social health level of citizens. The Pearson correlation coefficient between social inequality and social health equaled -0.512 at the significance level of 0. Therefore, the hypothesis is confirmed. Social health determinants may include obeying the law, wealth equity, and public access to contribution over the decision-making process. Sharbatiyan and Tavafi (2015) found an average and high rate of social health of youth in this city. Their results indicated that social coherence (one of the dimensions of social health) and social contribution had the highest and lowest rate, respectively.

Chalabi and Rahbar (2012) assume that socioeconomic inequality mechanisms affect health and health-oriented behavior. Stress, sense of economic inequality, social dissatisfaction, social class, self-confidence, sense of social inequality, and determinism have direct and indirect effects on two dependent variables of health and health-oriented behavior. Baoosh Shiani and Mousaei (2017) believe health is a fundamental and indisputable right of all humans and is considered an important factor in the socio-economic field. Health can be used as a starting point for social change to achieve a superior objective such as justice. The impact of poverty and inequality mechanism on health is that the economic inequalities cause inequality in accessing health services by making a social slope. Therefore, the importance and necessity of studying factors affecting health inequality stem from a health nature that is a universal right.

This subject can be explained based on Durkheim's theory, which indicates that higher social capital or integration improves the health status of society. Moreover, social coherence is lower, crime and violence, and death rates are high in societies with high inequalities. If social relationships and links are not desired in some societies, and people avoid rational social interactions, the individualism phenomenon appears, and social coherence decreases. The declined social interactions (social capital) cause social isolation and reduce the social health of citizens. Moreover, high social capital is a variable that protects people against mental diseases by creating a supportive social environment. Therefore, the findings are consistent with results obtained by Chandola et al. (2007), Benifatemeh et al. (2014), Chalabi and Rahbar (2012), Lahelma et al. (2004), and Samsami et al. (2007).

The results indicated a significant nexus between a health-oriented lifestyle and dimensions of health. Coefficient correlation between lifestyle and social health (0.477) was confirmed in a positive direction, confidence level greater than 99% and an error level lower than 1%. In other words, there is a direct and significant correlation between lifestyle and social health. Research findings revealed a direct and positive significant nexus between social health and lifestyle dimensions. Moreover, there is a positive and significant correlation between lifestyle dimensions (except for body management) and social health. The hypothesis is confirmed considering the abovementioned points. Ghanbari Moghadam et al. (2015) found that 95% of elderly living in Tehran had a moderate lifestyle, and multiple regression analysis results indicated a significant relationship between lifestyle dimensions and general health subscales. They also found a significant inverse relationship between lifestyle and general health scores. Tajik et al. (2016) assume that unequal access to healthcare services reflects socioeconomic differences, including economic quintile, insurance coverage, and lifestyle.

It can be explained that Berkman believes that social network affects health by fostering moral contribution and making a person

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involved in social processes, spending leisure time with friends, participating in social and occupational roles, willingness to engage in religious activities and entertainment. Therefore, a person's social health is improved when they participate in social events through opportunities provided by membership in social networks and defined significant social roles, including social, occupational, familial, and parental roles. Therefore, the results are in line with findings obtained by Sabbagh et al. (2011), Tajik et al. (2016), Samsami et al. (2007), and Hezarjaribi and Arfai (2012).

The results showed a significant nexus between health services and dimensions of health. Research findings revealed that the coefficient of person correlation between access to health services and social health equaled 0.590 at the significance level of 0. There is also a positive and significant nexus between access to health services and dimensions of social health. In other words, high access to health services increases social health and its dimensions. Accordingly, this hypothesis is confirmed. The social health of individuals depends on their welfare or well-being level, indicating how they live with others, how they interact with each other, and how they react to social institutes and traditions. The results were matched with findings obtained by Navina (2015), Abdi (2014), Yazadn Panah (2015), and Samsami et al. (2007).

According to the results of this study, the government should boost the cooperation morale among citizens for health improvement and orientation, improve the health level of the poor and vulnerable people by preparing suitable plans for them, narrow the gap between poor and rich groups, and create a positive health slope for all socioeconomic classes to improve social health. Moreover, it is important to decrease social inequalities in different cultural, political, and social dimensions to improve social health. Paying attention to the role of education and educational centers is considerable in developing social health and its five dimensions introduced by Keyes.

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