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A Study To Determine The Connection Between Financial Status And Diseases

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Abstract

A dissertation involves an up-close, in-depth, and detailed examination of a particular research, within its real-world context. For this, we perform research and get observation. Research knowledge is very important in every field. One must be familiar with the problems related to that field so that he/she may solve them & become a successful person or professional.

I have undergone my dissertation on "**A study to determine the connection between financial status and diseases**" about 300+ patients nearby Chandigarh and its nearest regions. This report is based on my knowledge.

Statement of Problem: A study to determine the connection between financial status and diseases.

Material and method: In-depth analyzes and cross-sectional studies conducted in clinics and hospitals for poor and middle-class people. Poor people have poor health and die young. A poor patient who was cared for ill from his one of the selected clinics and hospitals during the study period was interviewed using a structured interview plan and questionnaires to assess stress and related factors.

This study aimed to determine the association between financial status and illness.

Results: There were 300+ participants for the study. All subjects had moderate to high levels of economical stress, with 39% reporting high perceived stress.

Higher-than-average mortality rates among the elderly, infants and mothers, higher levels of disease (e.g. tuberculosis, cancer, liver disease, and asthma), lower access to health care and social protection, and gender inequality among women.

Health is also a very important economic benefit, especially for the poor. Your existence depends on it. When the poor and vulnerable get sick or injured, whole households can be caught in a vicious circle of declining incomes and rising health care costs. Cascading effects may include diverting time to earn an income or from schooling to nursing. You can also force the sale of assets that are necessary for your livelihood. Poor people are more vulnerable to this downward spiral because they are more susceptible to disease and have more limited access to health care and social security.

Conclusion: It was concluded that all parents likely to be stressed particularly if counseling sessions are not favorable.

We conclude that diseases remain common in populations characterized by poor housing conditions, drug use, and infection. Linking a major medical provider with community-based organizations is an

effective means to provide highly targeted screening services to a poor population at serious risk for disease acquisition and transmission.

They should also have proper guidance and knowledge to prevent the diseases in early stage so that they can overcome in less time and cost. They should aware of the diseases which can affect the all members of family.

Keywords: Infection, housing conditions, gender inequality, poverty, health, women, children.

Introduction

Background Of The Study

In recent years, our patients have experienced significant increases in the cost of healthcare treatments and medical supplies. As a result, they are more conscious of the quality of care and treatment and are more willing to use healthcare services that maximize patient satisfaction.

Poverty studies have shown that low income is associated with poor health. The person's income decreases; he gets sick earlier and dies. Additionally, some research shows that people living in poverty may be at greater risk of infection.

India is rapidly industrializing, with about a third of its population living in urban areas and many from rural areas moving to cities for jobs, better living conditions and access to medical facilities. With the rapid expansion of cities, the urban poor around the city are also increasing rapidly. Urban poverty is multifaceted with its dimensions including many complaints, disadvantages and risks arising from the inability of the urban poor to access basic services such as water and sanitation, shelter and livelihoods, as well as health, child mortality and education social protection and the characteristics of support and voice became evident. Informal settlements or slums, the most visible form of urban poverty, often lack water and sanitation, and inadequate housing means that slum dwellers pay more than those living in communities that benefit from services such as clean water and electricity. Many of the urban poor rely on informal work and face social poverty (lack of access to education, health and social security).

Poverty is static only from the direct effects of deprivation (lack of shelter, food, transport, etc.). The long-term consequences of non-homeostatic attribution and unhealthy behaviors are many diseases that can lead to premature death if not treated properly (Braveman & Gottlieb, 2014; Kondo, 2012). Chronic poverty increases the risk of heart disease, high blood pressure, stroke, obesity, diabetes, respiratory disease, cancer, diabetes, HIV/AIDS, disability, dental disease and chronic kidney disease. Disadvantaged communities are more vulnerable and more vulnerable to crime, violence and environmental stress.

The impact of poverty is evident across the lifespan, and it is worth examining poverty from a lifetime health perspective. In the framework of lifelong health promotion, health is regarded as the result of a variety of actions operating within the genetic, biological, behavioral and social contexts intertwined with the change a person creates – economic impacts on health outcomes play an important role (Halfon and Hochstein, 2002).

For example, low birth weight in infants is associated with a higher risk of diabetes, asthma, heart disease, high blood pressure/hypertension, sickness and premature death. Poor children are more likely to experience stress and chronic illness, including family conflict, child abuse, single parenting and abuse.

Introduction to the Study and Definitions

Poverty is the real history of India. Three quarters of the population live at or below health level. This means that 70-90% of their income is spent on food and other consumption. In this context, health, education, housing, etc. social security support is important in matters. Ironically, India has one of the largest private healthcare systems in the world, with over 80% of outpatients supported by out-of-pocket costs. Public health service is inadequate. Public health and hospital services are mostly located in cities where only 25% of the billion people live. Prevention and support, such as family planning and vaccination, is mostly available in rural areas. The private sector is responsible for outpatient services and more than half of hospital care in rural and urban areas. Also, most private doctors are not authorized to provide routine medical treatment because they have adopted other systems of medicine (Indian systems such as Ayurveda, Unani, Siddha, and Homeopathy) or, worse, they have not received training. But these doctors are the ones who are more likely to be cured of the poor out of. This poses a risk to people who are already poor. Like America, India's healthcare sector is driven by demand from the healthcare sector and is growing, especially against the backdrop of new treatments.

As health assessments become more important, patients are becoming more concerned about how their health care needs are being addressed by the health care system. Health assessments play an important role in identifying and assessing the specific needs or health conditions of individuals or large populations. Healthcare organizations typically conduct health assessments by conducting physical examinations using health assessment questions or assessing patient health status via remote patient monitoring solutions.

Diseases of poverty often co-exist with malnutrition and are prevalent. Poverty increases the likelihood of developing these diseases. Because lack of access to shelter, safe drinking water, nutritious food, sanitation and medical services leads to poor health behavior. Studies show a positive correlation between good health and high income. This means that people who make more money tend to get sick less and have better overall health. Poor health and higher rates of disease are more likely to be associated with low-income populations.

Need Of The Study

This study evaluates and determines the relation between financial status and diseases. This study aims to add the literature by evaluating the role of different conditions of the poor people which affects their health. People living in low-income households are less likely to have health insurance or to receive medications and treatments that can treat chronic health conditions. Low-income families also have limited access to preventative and specialized care. Perhaps the most prominent statistic about health and wealth concerns life expectancy.

It is not surprising that high-income earners can afford to attend gym memberships and dedicate more time to improving their physical health. High-paying occupations offer comprehensive health insurance. We also know that nutritious foods such as fresh fruits and vegetables are more expensive than instant foods that are high in calories and cheap.

The health impact on low-income households will be felt more by minorities. High morbidity and poverty among minority groups are certainly related. One study also linked poor mental health among minorities with lower income levels.

The term "low income" generally refers to individuals and families whose annual income is less than 130-150% of the federal poverty level. For example, people with a monthly gross income of 130% of the

federal poverty level qualify for the Supplementary Nutrition Assistance Program (SNAP). 8 Medicaid is available to families whose income is below 138% of the poverty line. Poverty and low income are associated with a range of negative outcomes, including shortened life expectancy, increased infant mortality, and a 14% increase in mortality. Individual and societal-level mechanisms mediate these effects. For individuals, poverty limits the resources available to risk aversion and healthy behavior. Poverty also affects the productive environment (i.e., the physical human-made physical places where people live, work and play, including buildings, open spaces and infrastructure), service, culture and reputation in society, each of which independently affects health.

India's rich healthcare system and culture presents many challenges to achieving health equity. Wealth, education and employment are main indicators of equity in India and these indicators can be compared internationally to measure and monitor health inequalities. Additionally, religion, caste and caste affiliation are important background factors of inequality affecting health and well-being in India. Wealth or income inequality determines health and access to health care. Assets, consumer spending, income and poverty (as measured by a population of living on less than $1 and $2 a day) are important indicators of occupational health and sickness and health services. Inequality at work determines access to and impacts on resources, as well as the impact of work on health. Working conditions and conditions, adverse working rules and seasons Work affects health and well-being.

Education inequalities determine human capital, health behaviors and access to health. Inequality and inadequate education for women are significant barriers to human development, especially for young people. Urban-rural and provincial inequalities include health risks, rights, access to infrastructure services (e.g. water and sanitation, air pollution), healthy behaviors (including smoking and alcohol consumption), and health care. Religious inequality affects health through social norms, relationships, and access to resources.

These differences diminished over time, but became flexible in certain contexts, such as diet and contraceptive use. Inequalities between groups and tribes affect health through differences in access to resources, inequalities in education, cultural expertise, discrimination, and access to health care. Information on tribal and minority groups is scarce.

Statement Of The Problem

“A study to determine the connection between financial status and diseases”

Objectives Of The Study

This research aims:

1. To explore the barriers to accessing modern healthcare services to the lower class families due the poverty.
2. To explore whether wealth effects of health interventions.
3. To determine the connection between economical condition and diseases.
4. To study the effect of diseases over lower income families and their future growth.

Operational Definitions

Poverty: Poverty is a state or condition in which a person does’nt has the financial resources and necessary means of livelihood. Poverty can have many social, economic and political causes and effects.

Knowledge: The knowledge refers to the correct written responses to the items as measured by structured questionnaire.
Effectiveness: It refers to the ability to produce desired results.

Scope Of The Study

Many studies have shown that the rich can expect to live longer than the poor. In the United States in 1980, men in the top 5% of income lived 25% longer than those in the bottom 5%. Recent findings in the UK show that the difference in life expectancy between the upper and lower classes of society has increased from 5 to 9 years (Deaton, 2016). Indeed, socioeconomic status, education, wealth, race, location, and social status correlate with mortality and morbidity. Healthy people are better workers: they work harder and smarter.

Healthy students are more knowledgeable, which helps them succeed in school and are more likely to form better relationships later in life. Much of the public health literature has been questioned because different populations receive different health care systems and because of doubts about the value of health care. McKeown (1979) concluded that improvements in living conditions such as housing and nutrition lead to increased life expectancy. Robert Fogel (1997) also found that food is important in business and development. (Deaton, 2016). Therefore, I will not discuss the impact of race, location, and access to healthcare here; I will focus on health and wealth relationships and things like education, family, and early childhood. The relationship between health and wealth is called a "gradient": the higher the income, the better the health. Poor health reduces working hours and increases health care costs while lowering income, all of which make life worse than before. I believe being healthy is a way to be rich.

Research shows the impact of poverty and how it affects children. These effects persist into adulthood and may affect future generations. For example, children who grow up with adverse childhood events (ACEs) are more likely than adults to smoke (Woolf 2015). Among the multiple effects of poverty on generations, researchers also point to education. Children living in poverty are less likely than children of high-income parents to graduate from college, and this education gap widens over time (Woolf 2015).

Delimitations

Much of the research about the effects of poverty on health is limited to identifying health disparities. This study has some limitations. This study is limited to the poor families resides nearby Punjab only. This study is limited to only those subjects who were taking counseling or medical care from selected clinics and hospitals of Punjab and nearest cities.

Research Question

What are the main problems faced by the poor people during the treatment or care of the diseases they suffered.

Variables

Independent variable

The independent variable is the antecedent. An independent variable is a variable that is assumed to cause or influence the dependent variable. In this study, independent variables refer to subjects for age,

gender, place of residence, education level, and monthly income.

Dependent variable

The dependent variable is the outcome. The dependent variable is that variables which are affected by independent variables. In this study, blood pressure, weight, blood glucose level, etc. are dependent variables.

Hypothesis

H1: There is a significant relation between economical lower people and the diseases.

Summary

Poverty occurs when individuals or families do not have the resources to provide basic needs such as food, clean water, shelter and clothing. It also includes the lack of access to resources such as health, education, and transportation. India accounts for a large portion of the world's diseases estimated to exceed 16.8% of the world's population. An important factor in improving the situation is the need for good and relevant evidence to help India make informed decisions. A comprehensive review of the latest health research in India is not possible. Without objective data on the shortcomings and strengths of India's current health research output, it is difficult to plan to improve health-related research output to improve health in India. We analyzed the 2002 health survey results of India and compared them with the burden of disease estimates to identify areas requiring special attention to facilitate action. It has been effective in reducing diseases in the world's second most populated country.

Review Of Literature

Review the previous studies is an important step in research. It is the search of published articles for information on research topics. It provides a basis for further research, clarifies the need for the study, clarifies the feasibility of the study, sets out the limits of data collection, and guides findings to other research as well as the establishment of a broader scientific discipline of information science which develop positive thinking.

Review of literature is an essential step in research project. It is a systematic search of published work to gain information about a research topic. It provides the basis for further research, demonstrates the necessity of the study, clarifies the feasibility of the study, and reveals limitations in data collection and interaction of findings from the study to another with a hope to establish a comprehensive study of scientific knowledge in a professional discipline, from which valid theories developed.

A literature review is the systematic identification, search, analysis, and summary of literature containing information about the research question. A literature review helps to lay the foundation for the study and also inspires new research ideas. A literature review provides readers with the background for understanding current knowledge on a topic and eliminates the significance of new study.

The purpose of the literature review is to determine what is already known about the topic which is under study and to locate theoretical or conceptual formulations that will help guide the study.

This study is a literature review of the relationship between financial status and illness, spanning both health care and community behavior. Based on the articles reviewed, the data suggest that effective practice of good ethics in community-based organizations can reduce the occurrence of economic problems, such as adequate counseling, medical awareness, and clean lifestyles. It shows that there are some preventative measures that can be taken.

Relevant research and non-research literature is reviewed to broaden the understanding and development of the selected topics under study. The in-depth review of literature revealed the research literature pertaining to the prevalence and incidence of obsessive compulsive disorder, the obsessive beliefs and family functioning of patients and general population.

The literature review is organized under the following headings:

1. Impact of Poverty on Health
2. Poverty and health
3. The direct causal effects of household wealth on health
4. How does financial status affect health
5. India's Poverty Profile

Literature pertinent to this study was reviewed to understand the potential and significance of the study and to guide its design and implementation, are presented in this chapter.

In this study the researcher has gathered total 20+ reviews of literature related to present study, which includes studies related to the relation of health and the income status, are as follows;

The Milbank Quarterly has been published over his eighty years and features original peer-reviewed research, policy reviews and analysis, and commentary from academics, clinicians and policy makers. Its multidisciplinary approach and commitment to applying the best empirical research to practical policy-making provides an in-depth assessment of the social, economic, historical, legal and ethical dimensions of health and public health policy. Most social determinants research and interventions focus on soloed solutions (housing, food, utilities) rather than on a root solution such as financial health. Numerous studies have shown that wealthy people expect to live longer than poor people. In the United States in 1980, a man whose income was in the top 5% of the distribution lived 25% longer than a man whose income was in the bottom 5%. Recent results in the UK show that the difference in life expectancy between upper and lower social classes has increased from 5 to 9 years (Deaton, 2016). Indeed, socioeconomic status, education, wealth, race, place of residence, and social class are associated with mortality and morbidity. Healthier people are better workers: they work harder and smarter. Healthy students have higher cognitive abilities, which give them better performance in school and later an opportunity to attain higher social status.

McKeown (1979) concluded that improvements in living standards, such as housing and food, increase life expectancy. **Robert Fogel (1997)** also found that nutrition is important in the process of economic development and growth. (Deton, 2016). Therefore, we will not discuss race, location, and the implications of access to healthcare here. It primarily focuses on the relationship between health and wealth, as well as factors such as education, family and early childhood. The relationship between health and wealth is called the 'slope'. More income improves health, and the poor have worse health than the rich. In other words, a higher slope means better health.

Ahmad Alqassim and Maged El-Setouhy (2022) conducted a study on Impact of Poverty on Health and concluded that poverty is when a person does not have enough money to buy a minimum of food, clothing, medical care, education and everything else necessary to lead a healthy life. Poverty is recognized as a serious problem in countries around the world. In developing countries, on the other hand, increasing poverty is a problem. In addition, the spread of COVID-19 has had a significant impact on increasing poverty, especially in developing countries. Poverty affects health in many ways. Malnutrition is a condition in which poor people cannot find food, and it can be unhealthy even when food is available. They also suffer from starvation which causes children to starve to death. No access to

healthcare, which is a huge barrier because the poor cannot afford or buy the medicine they need. Poverty is associated with a higher risk of disease, infection, and early death. The link between poverty and health is still very important, but researchers differ in determining who affects the other. For this reason, developing countries should ensure economic cooperation and encourage the development of countries. Poverty is not only a lack of money, but also a lack of resources to obtain the necessities of life. Poverty and health always support each other. This relationship emerged in 1948, when WHO defined health as a state of complete physical, mental and emotional well-being. In 1987, the Alma-Ata Declaration began discussing health injustice. This opened the door to thousands of projects, proposals and social media posts.

Although the relationship between poverty and disease is clear, money is unequally distributed. The Global Fund invests $4 billion a year in AIDS, tuberculosis and malaria, while other diseases do not receive funding. This is why they are considered neglected tropical diseases. However, the relationship between health and poverty is not limited to communicable diseases, but also includes other problems such as malnutrition and injury. In this section, we evaluate the relationship between poverty as a predictor and health as an outcome.

Sally Murray (2006) conducted a study on Poverty and health to evaluate the relation between the poor and the diseases. Their study found the result poor people also tend to have less education. They often have less knowledge of health promotion and when to seek health care; for example, poor women access less spawning services and have worse reproductive outcomes than privileged women. These effects are not limited to birth: Children born to women with five years or more of primary education are 40 percent more likely to survive than children born to uneducated women. Extreme poverty affects health in many ways, making people capable, empowered and empowered. Evidence from around the world supports the link between poverty, hunger and poor child health. Children's poor health and hunger lead to poor education, so they cannot find a good job and support their next family. Therefore, the vicious cycle of poverty management continues.

Nazim Habibov, Alena Auchynnikava and Rong Luo1 (2019) studied about the direct causal effects of household wealth on health. They discussed a few specific ideas that might link poverty to poor health, and consider how poverty affects community health. This hypothesis was tested with data from a recent cross country study in 12 post-Soviet countries and Mongolia using classical regression (OLS) and standard deviation 2SLS regression. The results show that poverty leads to poor health. The negative impact of poverty on health remains unchanged after controlling for various personal characteristics, health measures, trust in individuals, government, politicians and parties, and characteristics not seen in the country. Using different tools gives confidence that we can isolate the health effects of poverty and confirm that our results are not due to finitude. In addition, considering the negative impact of poverty on health, the use of country-level composite indicators (such as GDP and Gini coefficient) instead of country puppets, the use of self-declared poverty indicators instead of Target One, and the use of health variables, a binomial variable (poor and for poor health). We also performed a Wald equation test on the regression coefficients. The null hypothesis of the Wald test is that all the regression coefficients in a model are equal. The main results of these tests reject the coefficient equality assumption and show that the effect of each coefficient in the model is different from the effect of the other coefficients in the model. We see that poverty leads to deterioration of health. The negative impact of poverty on health remains unchanged even after controlling for various personal characteristics, public health measures; trust in people, governments, governments and parties, and characteristics not seen in the country. The

use of regression tools increased our confidence that we were able to isolate the health effects of poverty and that our results were not an endogenous phenomenon. In addition, the negative impact of poverty on health has been measured using country-level indicators (e.g. GDP and Gini coefficient instead of country dummy variables), subjective self-evaluation indicators of poverty instead of objective indicators, and an alternative theory of health based on binomial variables (poverty is clicky and not very good) instead of fixed variables.

Jagdish Khubchandani (2018) conducted a study on Poverty and Health Disparities. Data were collected from 50 randomly samples by using the structured interview schedule. He concluded that there was a growing awareness of the importance of health determinants (eg poverty, education, racial discrimination, etc.) in health inequalities. They examined the health consequences of income inequality and poverty in all segments of society, emphasizing the social determinants of health ("the cause"), and argue how health professionals can help reduce health inequalities.

Gary Ka-Ki Chung, Dong Dong (2020) conducted a study on Perceived poverty and health, and their roles in the poverty-health vicious cycle. Data were collected via focus group interviews with social workers (n = 8), chronic pain patients (n = 8), the elderly (n = 6), primary care physicians (n = 7) and informal caregivers (n = 10) . Published data was used to capture key themes using thematic analysis from the infrastructure. Their research concluded that poverty and poor health are linked. The link between poverty and health creates a vicious circle, especially in underdeveloped countries that do not have access to health care and services. The classic concept of the poverty-health vicious circle proposed by **Wagstaff** suggests that poor health affects people's wealth through loss of income and increases the suffering of health care costs, and that poverty leads to deterioration of health as people suffer from different types. Material and intangible deprivations related to health. They highlighted the financial and health benefits of poor health, increased debt, waste of property, and thus increased poverty. Although the concept has been developed, poverty-health studies have been largely documented in underdeveloped countries and it may be forbidden to generalize it to the problem of development facing political, economic, cultural and social problems.

Manon Haemmerli, Timothy Powell-Jackson (2021) conducted a study on Poor health quality for the poor. Using the Household Lifestyle Questionnaire, 150 households in 30 communities were associated with a sample of public and private healthcare facilities in the same community. Evaluation of the quality of healthcare facilities using facility service scores and experience scores developed using healthcare vignettes. A least squares regression model was used to investigate quality decisions in public and private hospitals. In both cases, there is a discrepancy in the quality scores of the main domains. In public areas, the disparity in readiness scores is greater between rural and urban areas and less between rich and poor.

AAFP Foundation (2021) conducted a study on Understanding Poverty and Low-income Status. They concluded that Poverty and low income are associated with many negative health outcomes, including decreased life expectancy, increased infant mortality, and increased mortality from causes of death. Individual and societal-level mechanisms mediate these effects. For individuals, poverty limits the resources available to risk aversion and healthy behavior. Poverty also affects the built environment (e.g. The physical creators of the places where people live, work and play (including buildings, open spaces and architecture), services, culture and reputation in society, each affecting their own health. Patients in poor health and others in pain are less likely to respond well to doctor's advice. Instead, interventions based on peer-to-peer storytelling or mentoring are more effective at overcoming cognitive behavioral

changes. Clinicians and caregivers can identify local peer support groups. Such situations are usually local hospitals, religious organizations, health facilities or nursing homes.

Michael Keane, Ramna Thakur (2018) conducted a study on Health care spending and hidden poverty in India. They concluded that India has a high level of out-of-pocket (OOP) healthcare and lacks a developed health insurance market. Traditional measures of poverty and inequality that address healthcare relationships with patients can be misleading. We believe that the medical costs of OOP should be considered as necessary medical expenses and not as part of consumption. Using this perspective, we develop a poverty and inequality index for India to account for poverty from out-of-pocket health care costs. We analyze the impact of out-of-pocket consumption costs on overall food distribution, not individual statistics such as poverty or low poverty. By examining the differences in OOP health costs in different parts of food distribution, we discuss how poor people can make mistakes and continue to work in the past. Finally, we also examine how accounting for healthcare costs affects measures of inequality such as the Gini coefficient and show how these measures can be affected by OOP on inequality.

Sanjay Kumar (2014) conducted a study on India's Healthcare System for Poor and Marginal Section of Society. Their research states that the Indian public health sector lacks adequate healthcare, a healthy workforce, and health-for-all policies and policies. It can treat only 18% of inpatients and 40% of outpatients because public health expenditures are still low, i.e. 2% of GDP compared to at least 5% of GDP recommended by WHO. The variation in immunization rates was lowest among scheduled groups, moderate among scheduled groups, and highest among unscheduled populations. Women's health is poor; they do not have adequate medical care, food and medical care in India. In all urban and rural settings, whether in public or private hospitals, women make fewer doctor visits than men. Even the proportion of money spent on the treatment of women in outpatient or inpatient treatment is still lower than in the treatment of men.

Mohd Faizul Hassan, Naffisah Mohd Hassan,,Erne Suzila Kassim, Yahya Mahyuddin (2021) conducted a study on Financial condition and Mental Health. They said as per their research that Depression, anxiety and stress are mental health problems that have become an important health problem in the world. Data from the Global Health Information Exchange show that poor health is on the rise, with 17.3%, or about 84 million people, in Europe suffering from brain health problems. Depression, anxiety, and stress are common symptoms of mental illness, and depression and anxiety occur as the two most common mental illnesses in society (Organizasyon, 2017). Similarly, a major public health concern is the increase in anxiety and depression. At the same time, findings from (Fiksenbaum et al., 2017) showed that 3.6% of the world's population showed signs of anxiety, and so did 4.4% of those suffering from depression.

Mental health problems can lead to premature death and affect quality of life. The study also revealed that mental health problems are one of the most significant contributors to the burden of other illness and disability. Mental illness is a common cause of loss of productivity and health. The loss of mental health is an additional burden for economic development. This study conducted a literature review called research synthesis to answer research questions.

Research synthesis and qualitative data analysis are gaining increasing acceptance in the social sciences. Aims to overcome the problem of researcher bias by using research and mixed research combining data among researchers, Search multiple research papers. Greater financial stress predicted increased depression and anxiety as well as negative anxiety. In addition, five studies have shown that the effects

of depression can also lead to psychological problems, which has a positive effect on the development of depressive symptoms. Symptoms of depression and anxiety increased during the GFC (Global Financial Crisis).

On the negative side, financial markets have affected people's financial problems and negatively affected their mental health. All have been shown that all aspects of mental health are affected by money.

Gouri Manik Manas (2019) conducted a study on Poverty and Health in India. The sudy demonstrate that the poor suffer from poor health and die sooner. Gender equality is not good, in addition to the health of women and girls, while having higher child and maternal mortality rates, higher rates of illness, and less access to health care and social protection. Health is also an important economic factor, especially for the poor. Their livelihoods depend on it. When a poor or disadvantaged person becomes ill or injured, the entire family can be caught in a vicious circle of income and health care expenses. The cascading effects may include the transition of earning or attending school time to patient care; they may also have to sell assets necessary to live. The poor are more vulnerable to this vicious cycle because they are more likely to get sick and have less access to health care and health insurance. Gender inequality is one of the main causes of poverty and poor health. Poor women and girls will be worse off in terms of wealth and rights in the family and society. Socio-cultural beliefs about the roles of men and women lead to inequality. Poor women and girls face greater disadvantages in accessing cash and financial services, services and health services such as 'voice'.

Certain groups of women, men and children are particularly vulnerable, such as older widows, unsupported women and children at home, and the experiences of street children. Women are also the main producers of health care, as they work in the family and are caregivers. But the health of women and girls who suffer from malnutrition, overwork and health neglect, aggravated by sexual abuse and personal abuse, is poor, including the health of their children. All of them have had a significant impact on human development and human resource development. Actions against gender inequality are keys to negative health outcomes.

Research conducted by the **Economic and Social Health Committee (CMH)** organized by the World Health Organization and the Indian International Economic Research Council (ICRIER) in **2003** illustrates the reality of health inequality in India. The report found that 4,444 people in the richest 20% received three times as much public health benefits as 4,444 people in the poorest quintile of the population. The poorest 20% of Indians have more than double the death rate, fertility and malnutrition levels compared to the richest 20%. The poor are more prone to pre-transplant diseases such as malaria and tuberculosis. 4,444 people spent an average of 12 percent of their income on health services, while the wealthiest spent 2 percent. Similarly, the death rate in rural areas is higher than in urban areas mainly due to lack of medical care. Explain the fact that India has one of the lowest healthcare budgets in the world; the report blamed the government, lack of resources and poor implementation of the program and policies. At the root of the inadequacy and injustice of India's healthcare system is the conflict between goals and resources. The state's role in health care fell short of stated targets as the poor were forced into a situation where they could access affordable private health care, the report said.

Maryam Sohrabi, Makmor Tumin (2012) conducted a study on Health Issues and Challenges among Indian Urban Poor. This study aims to explain some health problems and problems of some health indicators in India. They concluded that most Indians did not seek medical treatment when they were sick because they did not understand the disease's importance, accessibility, and financial concerns. The gap between private and public healthcare has been narrowed by rising healthcare costs and reducing the

number of free inpatients and outpatients. Among the poor, costs have a negative impact on hospital costs. Most healthcare costs are out-of-pocket and the government pays little for healthcare. Because of these high out-of-pocket costs, many Indian families live below the poverty line.

Summary

This chapter included the review of literature related to the connection between financial status and diseases. This review of literature has provided the investigator with an in depth understanding of the subject regarding, increase in population, diseases, which depend on the financial conditions of the household of a family. It has given vast overlook on the poor health and medical awareness.

Material And Methods

In-depth analyzes and cross-sectional studies conducted in clinics and hospitals for poor and middle-class people. Poor people have poor health and die young. A poor patient who was cared for ill from his one of the selected clinics and hospitals during the study period was interviewed using a structured interview plan and questionnaires to assess stress and related factors.

This study aimed to determine the connection between financial status and illness.

Research Design

A research design is a strategy for using empirical data to answer a research question. The research design was a descriptive intervention study to determine the connection between financial status and disease. In this study, a structured knowledge questionnaire was administered to carry out the result of the research.

Research Setting

Research setting can be the general location and condition in which data can be collected for the study. Data for the present study was collected from some selected clinics and hospitals.

Variables

Variable is a commonly used term in research projects. A variable is a property of an organizational group or situation that can take different values (that is, different from person to person).

Independent variable

The independent variable is the antecedent. An independent variable is a variable that is assumed to cause or influence the dependent variable.

In this study, independent variables refer to subjects for age, gender, place of residence, education level, and monthly income.

Dependent variable

The dependent variable is the outcome. The dependent variable is that variables which are affected by independent variables.

In this study, blood pressure, weight, blood glucose level, etc. are dependent variables.

Population

The population under the study was the low income family's resident nearby my hometown and the uned

ucated patients which is/was suffered with any of the major diseases and taking treatment or training in any of selected clinics and hospitals.

Sample And Sampling Techniques

Sample was the small proportion of the population selected for the observation and analysis. Sampling is a process to select the representative units of a population in a research process.

The sample of the study comprised of 250+ subjects participated in the study.

Development Of The Tool

Tools for the data collection are the devices which a researcher can use to collect the data or samples.

The investigator has prepared the structured knowledge questionnaire and demographic data profile sheet to determine the connection between the financial status and the diseases from selected clinics and hospitals

.

Description Of The Tool

The tools were organized as follows:

1. Demographic data profile sheet
   Demographic data profile sheet was used for assessment of demographic variables such as age, gender, economical status etc.
2. Structured knowledge questionnaire
   Structured knowledge questionnaire consists of the questionnaire related to the connection between financial status and the diseases. It consists of more than 25 questions.

Content Validity Of The Tool

Validity refers to whether an instrument accurately measure what it is supposed to measure.

Content validity of tool was checked and verified by consultation with the guide and the co-guide regarding the validity of content and language of the tool.

Reliability Of Tool

Reliability of the research instruments is a major criterion for assessing its quality and adequacy. It is the ability of the data gathering device to obtain consistent result. The reliability of the tool was tested during pilot study.

Pilot Study

A pilot study is a small-scale version or trial run designed to test methods to be used in a larger, more rigorous study. Data from pilot testing intervention can shed light on a number of things, including the acceptability of the intervention to intended beneficiaries, intervention agent; the adequacy, comprehensiveness and clarity of intervention protocols; the appropriates of the intervention: the extent to which intervention fidelity can be maintained; the rate if retention in intervention and safety of the intervention. It is the first step in any research, often a small study that helps plan and refine the main study.

The pilot study was conducted on 15 subjects. The samples had been taken through google forms to test the feasibility of the tools. Formal permission was obtained from the authority. The consent was taken fr

om the samples by explaining the purposes of the study.

Ethical Consideration

Ethical approval was obtained from ethical committee of Desh Bhagat University, Mandi Gobindgarh, Punjab. Confidentiality and Anonymity of the subject‘s information had been maintained.

Procedure Of Data Collection

The main study was conducted on 300 subjects using google forms. The investigator obtained written permission from the authority of the selected clinics and hospitals prior to data collection. A written informed consent was taken separately from each sample. Appropriate orientation was given to all the subjects about the aim of the study. The nature of the tool and adequate care was taken to protect them from potential risk including maintaining confidentiality, security, identity etc.

Plan Of Data Analysis

Data analysis is a systematic analysis of research data and testing of research hypothesis using those data. The obtained data was analyzed in terms of the objectives of the study to characterize the sample.

Expected Outcome

The study has determined to assess the connection between financial status and diseases. The study will help other researchers to fill the gap or update their knowledge.

Policy Relevance

The ethical clearance was obtained from medical officers and institute ethic committee of the hospitals/clinics.

- The study subjects were explained about objectives activities and duration of their involvement.
- The subjects had full autonomy to participate in research and withdraw from the research at any time.

Summary

This chapter dealt with the research methodology adopted for the study. It includes the research design, research setting, population, sample size, sampling techniques, development of the tool, and method of data collection, pilot study, content validity and reliability, plan of data analysis, expected outcome and policy relevance.

Results And Interpretation

Data analysis enables the researcher to reduce, summarize, organize, evaluate and communicate numerical. This chapter deals with analysis and interpretation of data collected from a sample of 300+ subjects.

Analysis of data was done according to objectives of study.

The analysis an interpretation of data of the study was based on the data collected using the questionnaire (N=100). The results were calculated using the statistical analysis tool SPSS.

Objectives of study:

The objectives of the study are:

1. To assess the data of poor populations as per their age groups
2. To assess the data of poor populations as per gender
3. To assess the data of poor populations as per diseases
4. To assess the data of poor populations as per income level

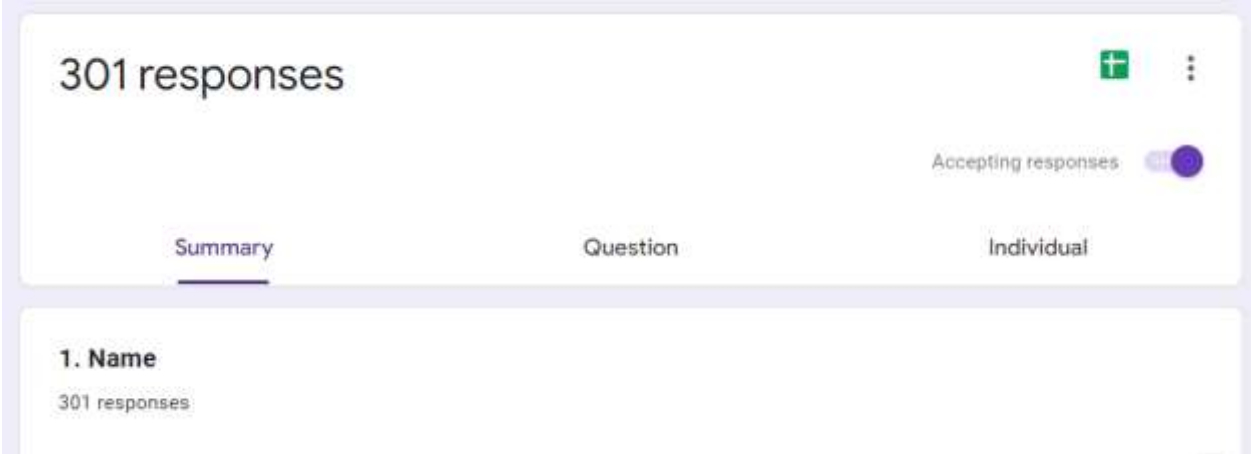


Figure 1: (Number of total Participants)

Table: Age-group of Participants

What is your age-group?		
Age-group	**Frequency**	**Percentage**
1 to 20 years	7	7 %
20 to 30 years	25	25%
30 to 40 years	35	35%
40 to 50 years	20	20%
Above 50 years	13	13%
Total	100	100%

Table 1 shows the age groups that the participants belonged to. 7 % of the respondents (N=7) belonged to the age-range of 1-20 years, followed by 25 % of the participants (N=25) belonging to the age-range of 20-30 years, followed by 35 % of the participants (N=35) belonging to the age-range of 30-40 years, followed by 20% participant in the age-ranges of 40-50 years and 13% for above 50 years. This implied that most of the respondents were young adults.

Figure 2: (Age of Participants)

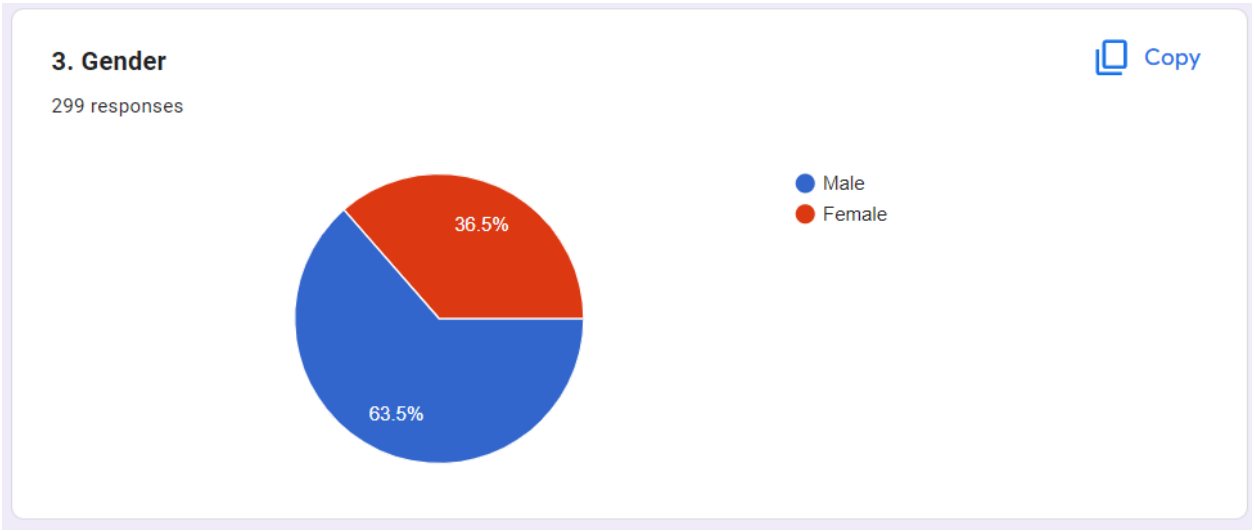


Figure 3: (Gender of Participants)

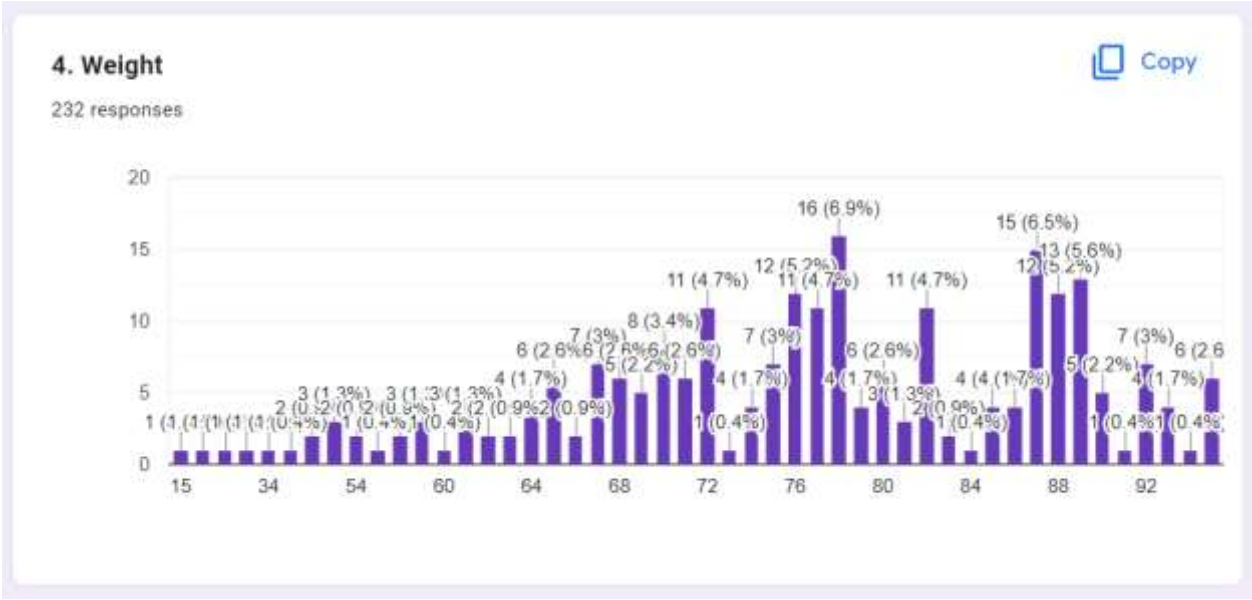
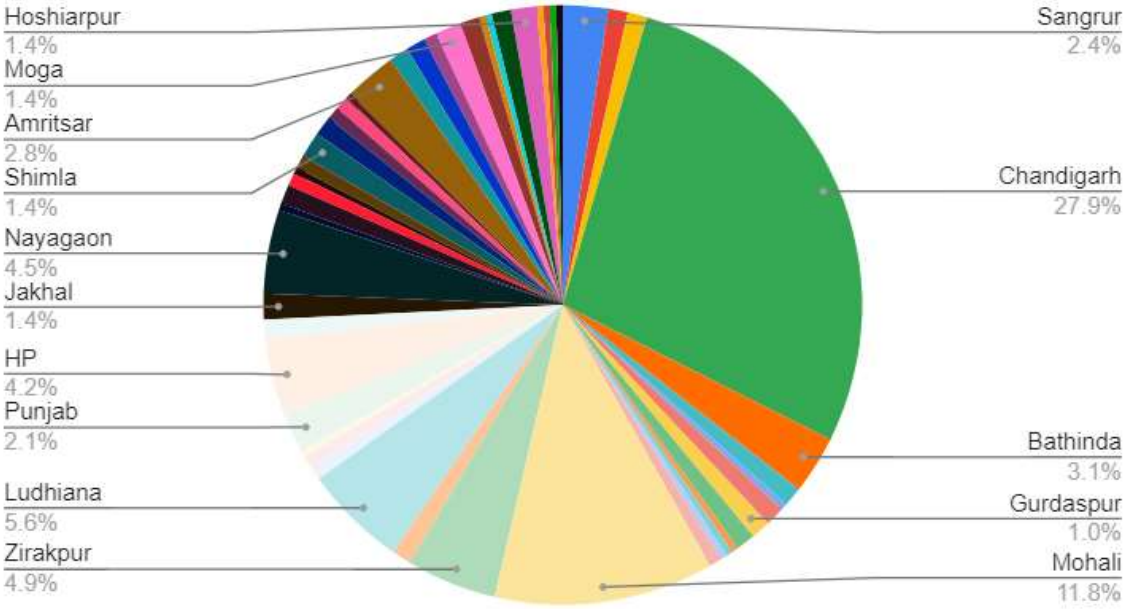


Figure 4: (Weight of Participants)

Table 1: Location of Participants

Location?		
Location	Frequency	Percentage
Chandigarh	27.9	27.9%
Mohali	11.8	11.8%
Nayagaon	4.5	4.5%
Ludhiana	5.6	5.6%
Zirakpur	4.9	4.9%
Bathinda	3.1	3.1%
Sangrur	2.4	2.4%
Amritsar	2.8	2.8%
Other Cities	37	37%
Total	100	100%

Table 2 depicts the populations belonging to different areas. Out of the total 100% respondents, 27.9 % of the respondents participating in this study belonged to Chandigarh, followed by 11.8 % belonging to Mohali, followed by 4.5% belonging to Nayagaon and other rest of all participants belongs to the nearest cities of Chandigarh.



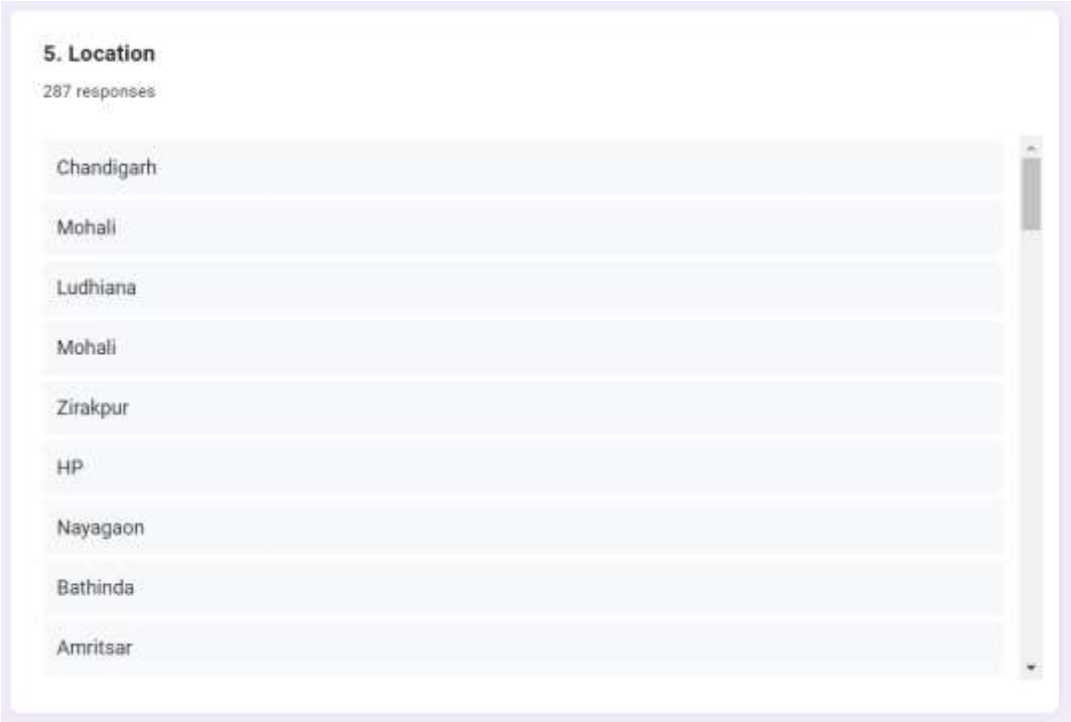


Figure 5: (Location of Participants)

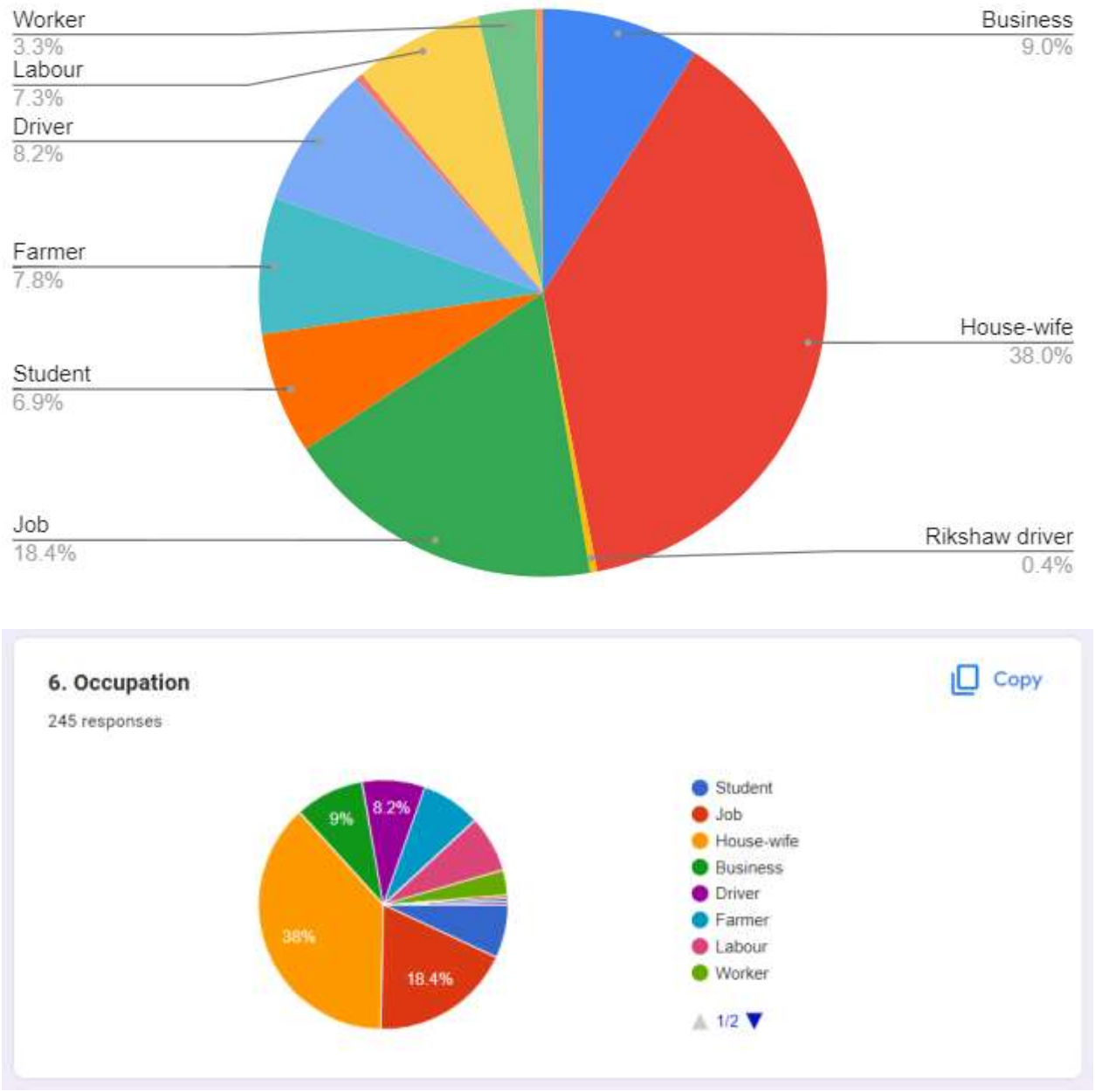
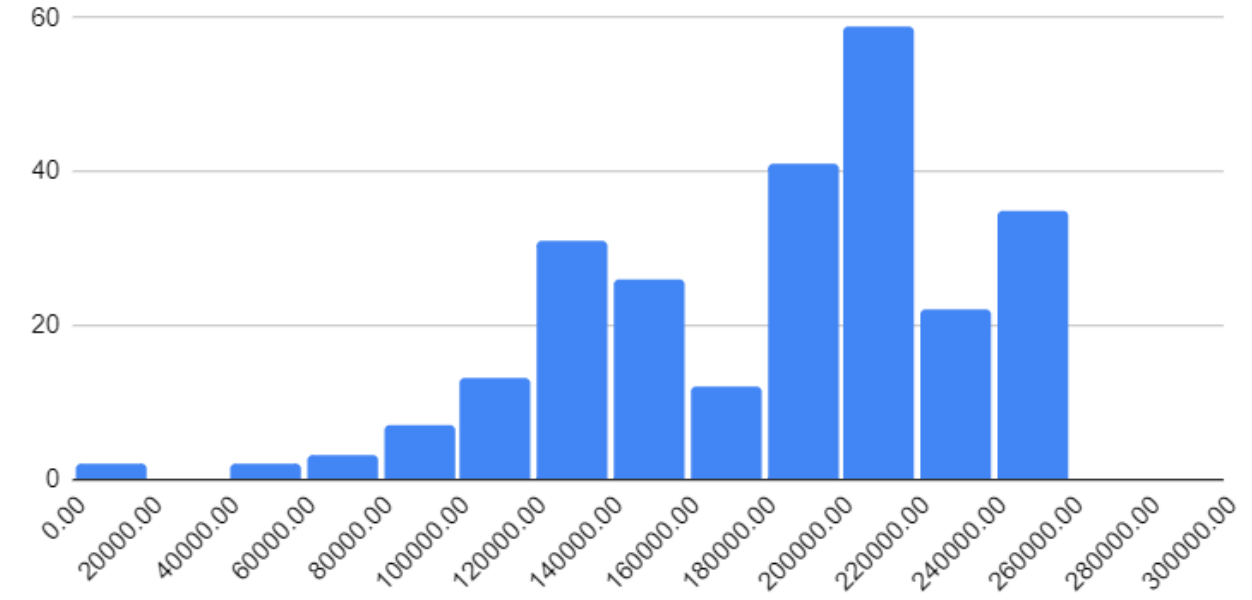


Figure 6: (Occupation of Participants)



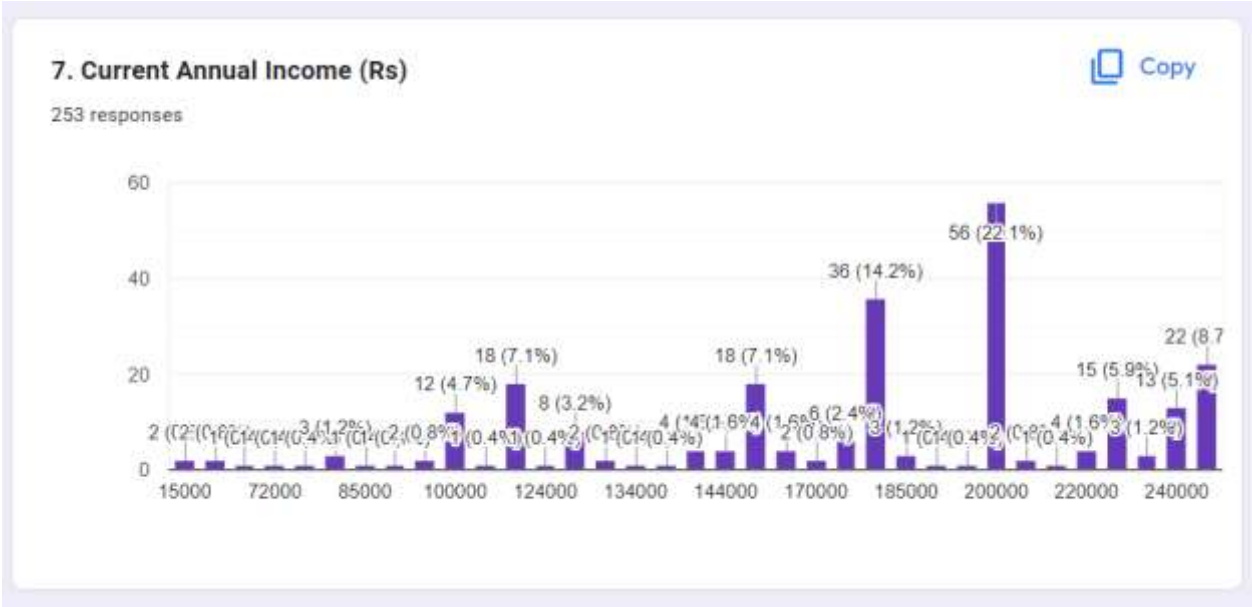
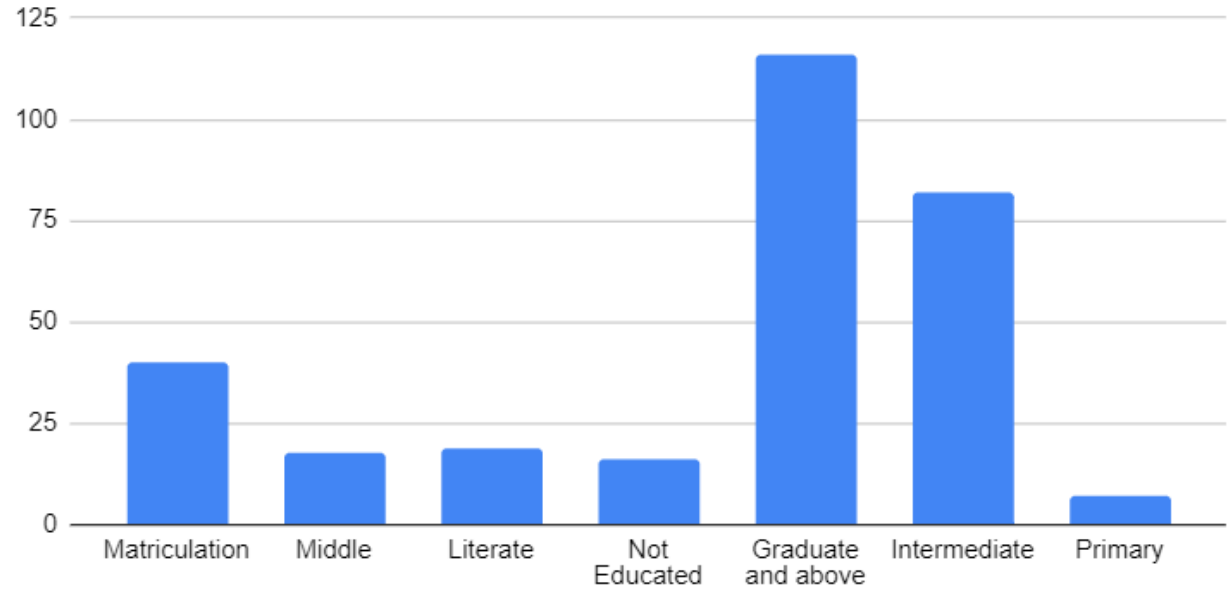


Figure 7: (Annual Income of Participants in Rs.)



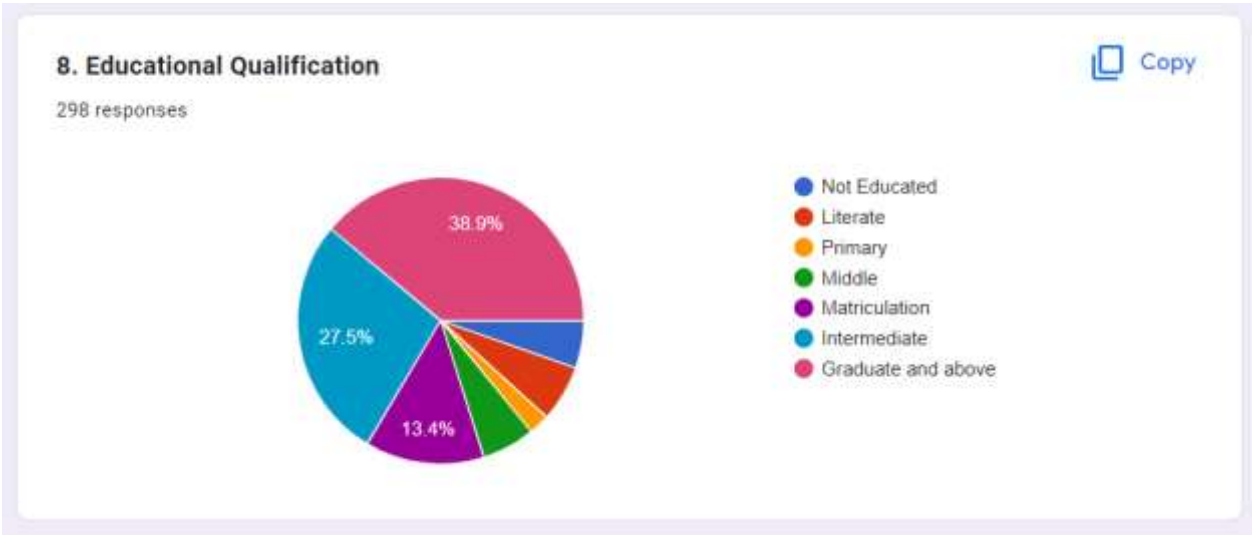


Figure 8: (Qualification of Participants)

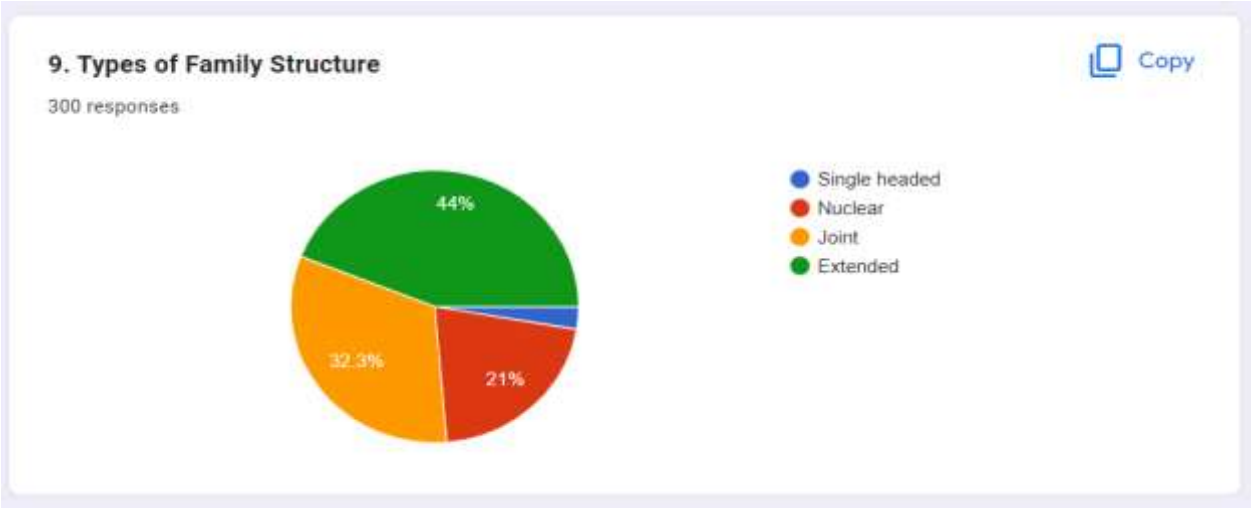


Figure 9: (Types of family structure of Participants)

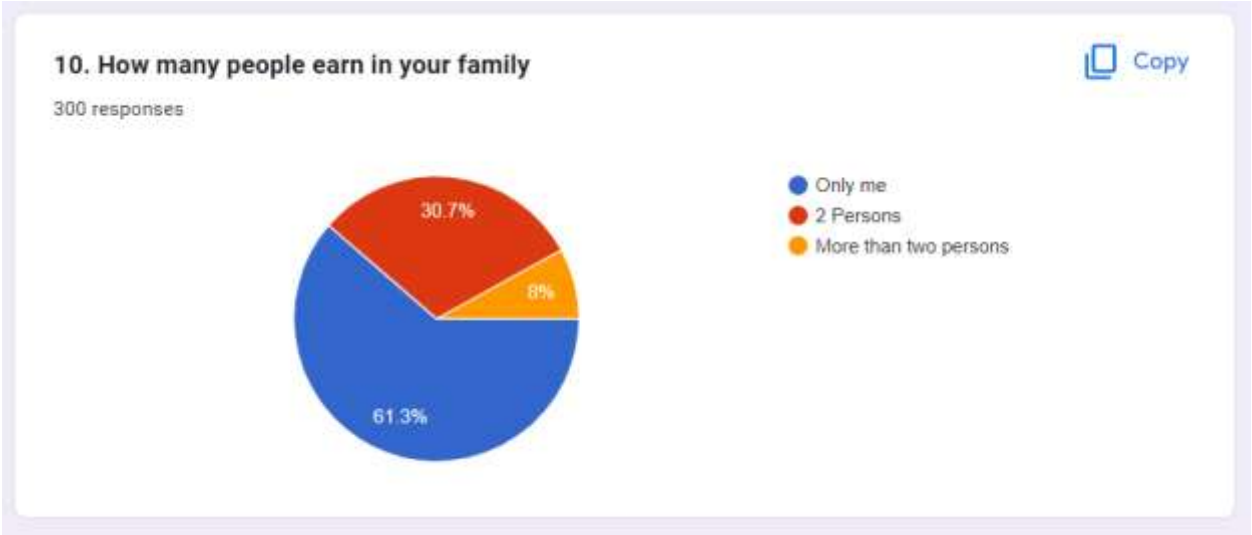


Figure 10: (Earning capacity of Participants)

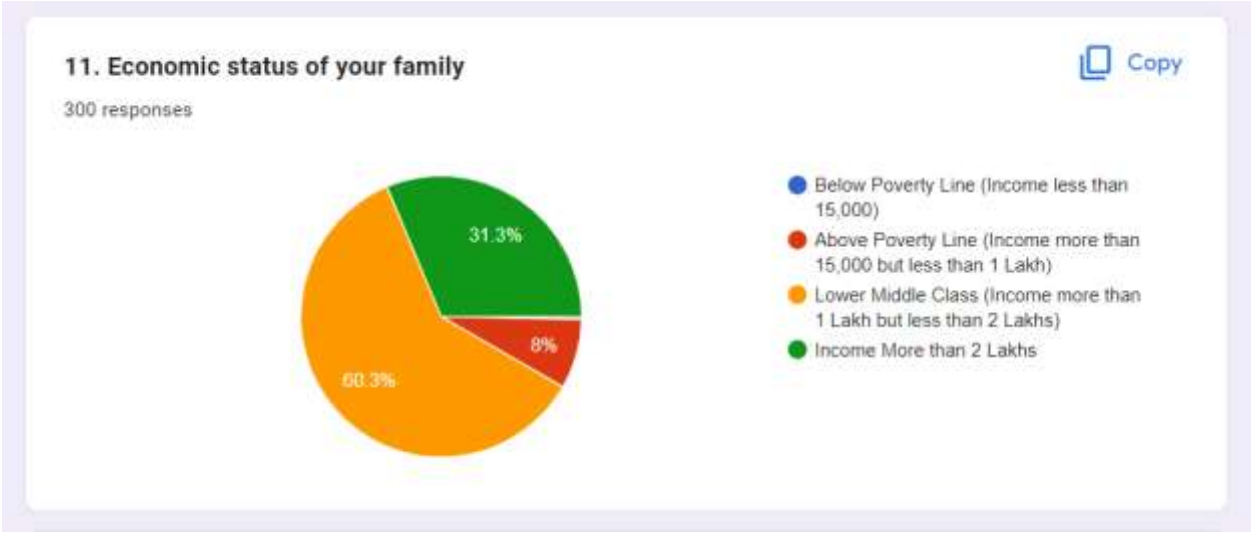
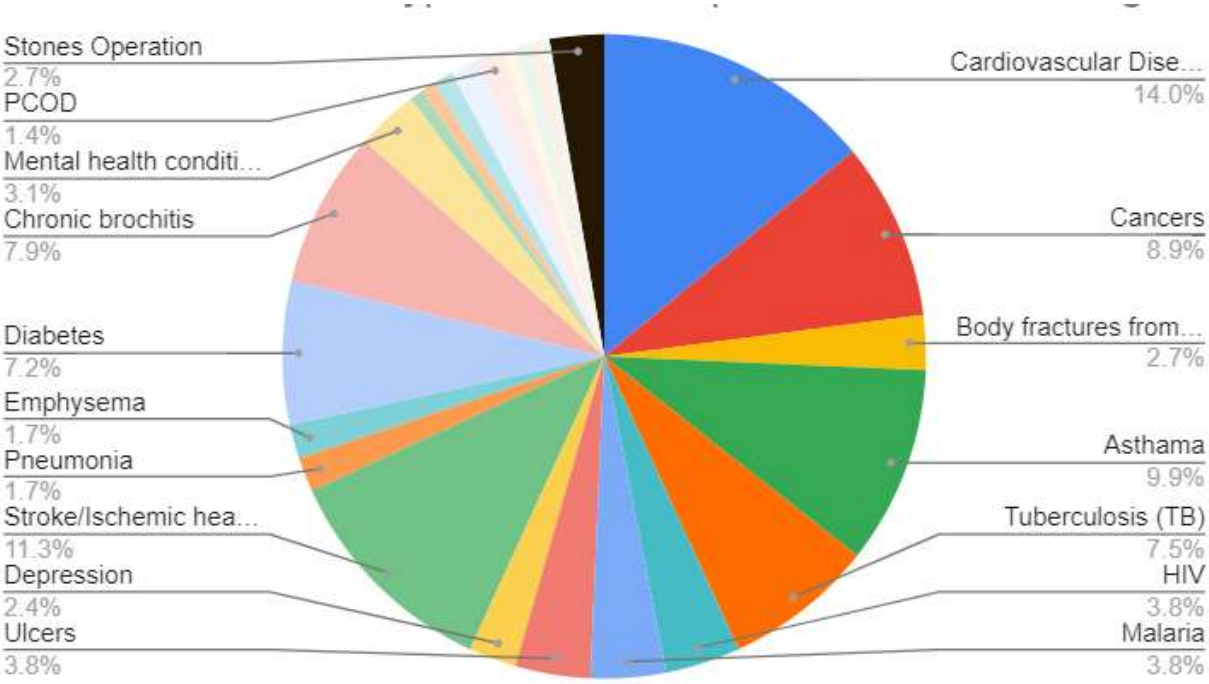


Figure 11: (Economical status of Participants)



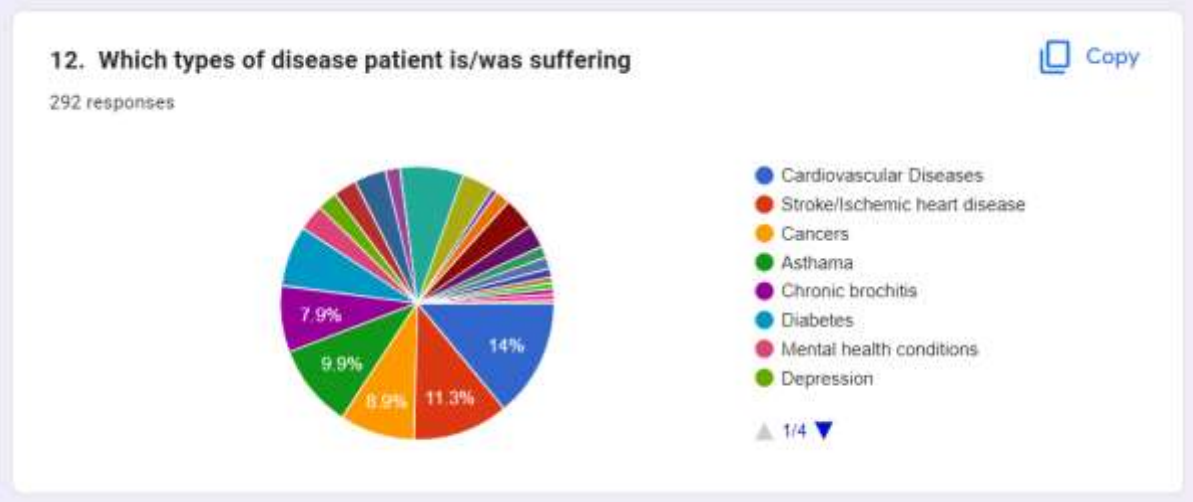


Figure 12: (Diseases of Participants)

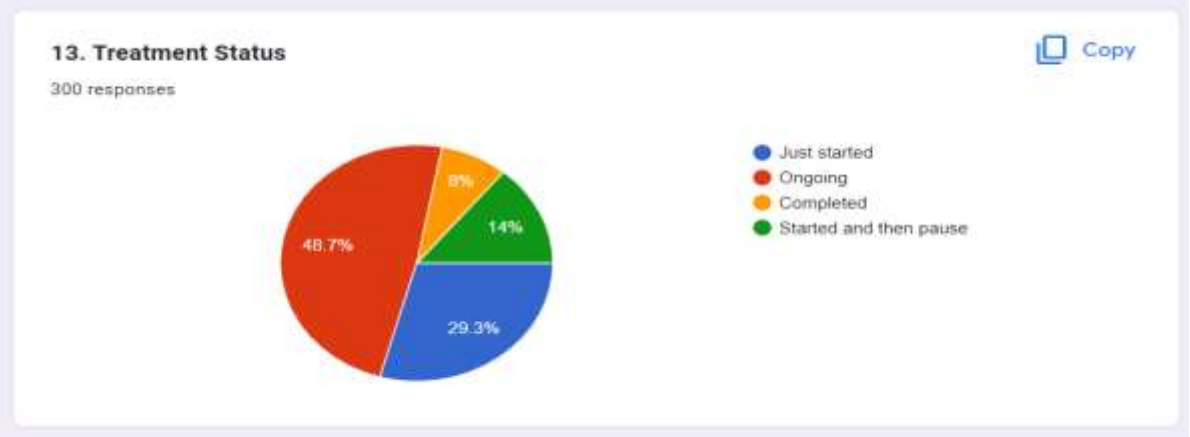


Figure 13: (Treatment Status of Participants)

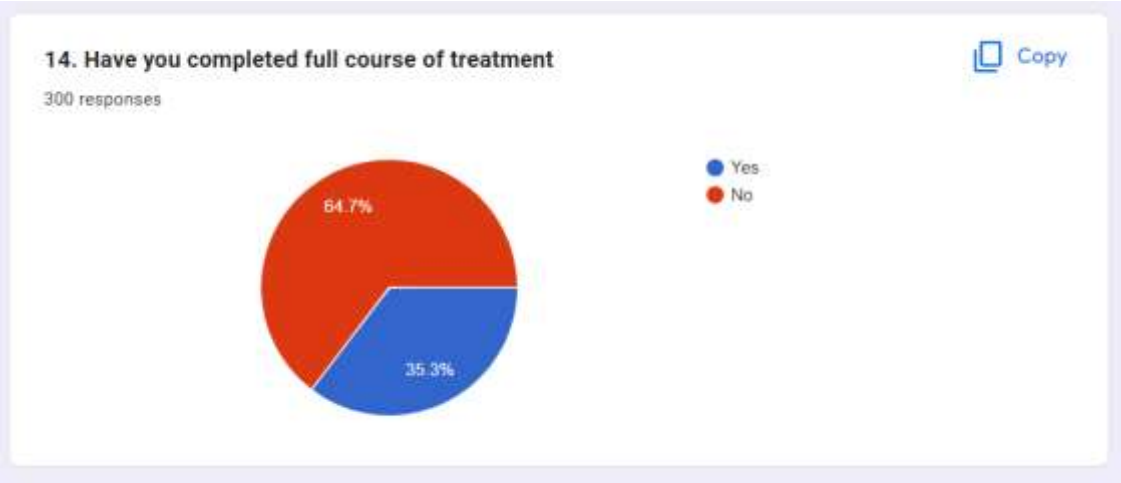


Figure 14: (Treatment Course completion status of Participants)

Table 2
According to the participants, Treatment Course completion status

Have you completed full course of treatment	YES	No	Total	p-value
	35	65	100	1.000
Total	**35**	**65**	**100**	

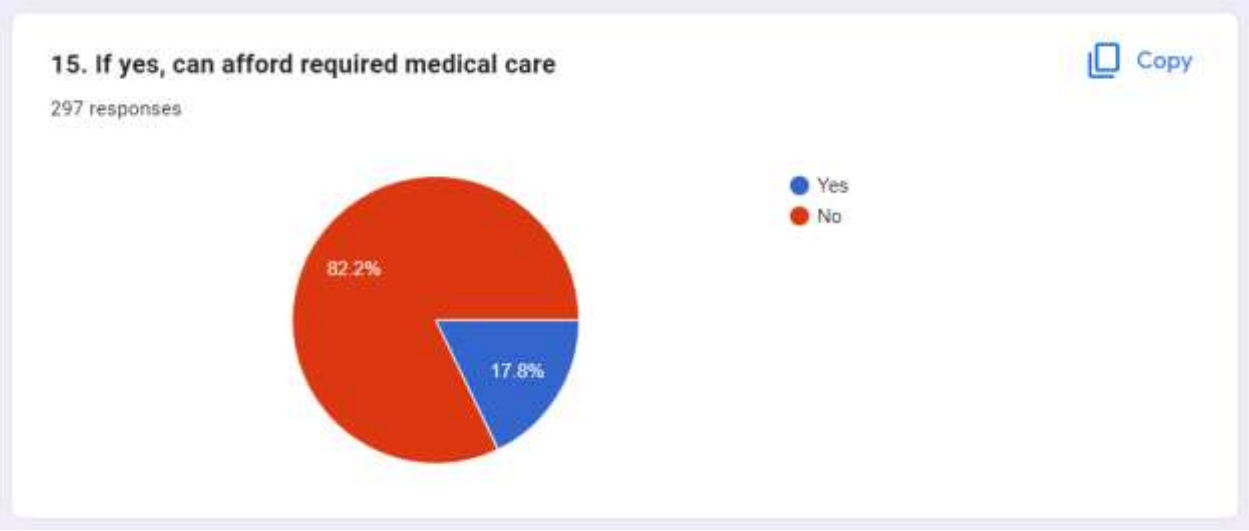


Figure 15: (Affordability of medical care of Participants)

Table 3
According to the participants, Treatment Course completion status

Have you completed full course of treatment	YES	No	Total	p-value
	35	65	100	1.000
Total	**35**	**65**	**100**	

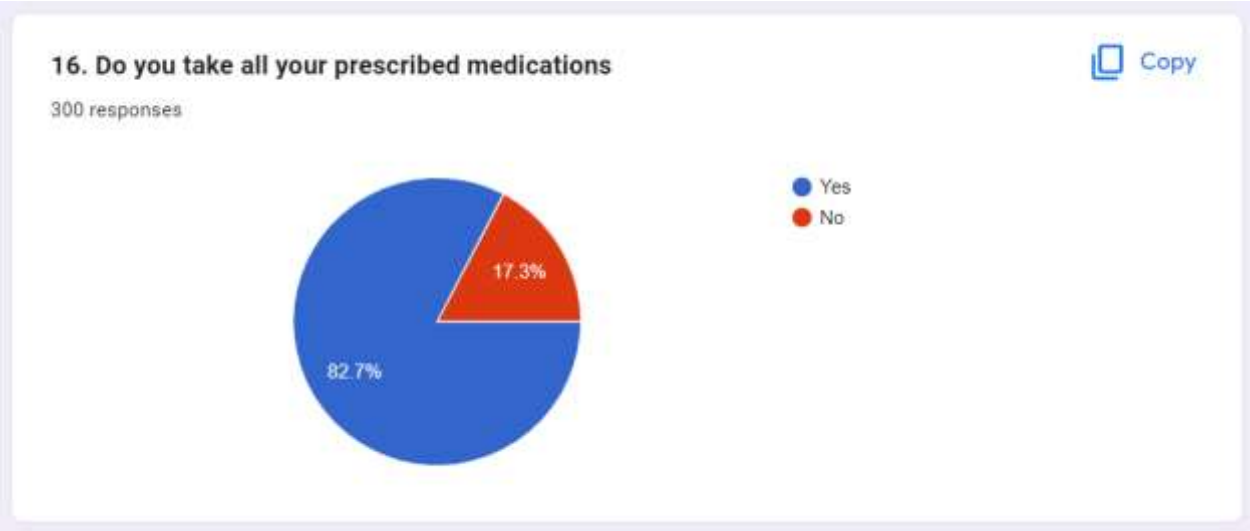


Figure 16: (Do you take all your prescribed medications)

Table 4

Do you take all your prescribed medications	YES	No	Total	p-value
	82	17	100	1.000
Total	**82**	**17**	**100**	

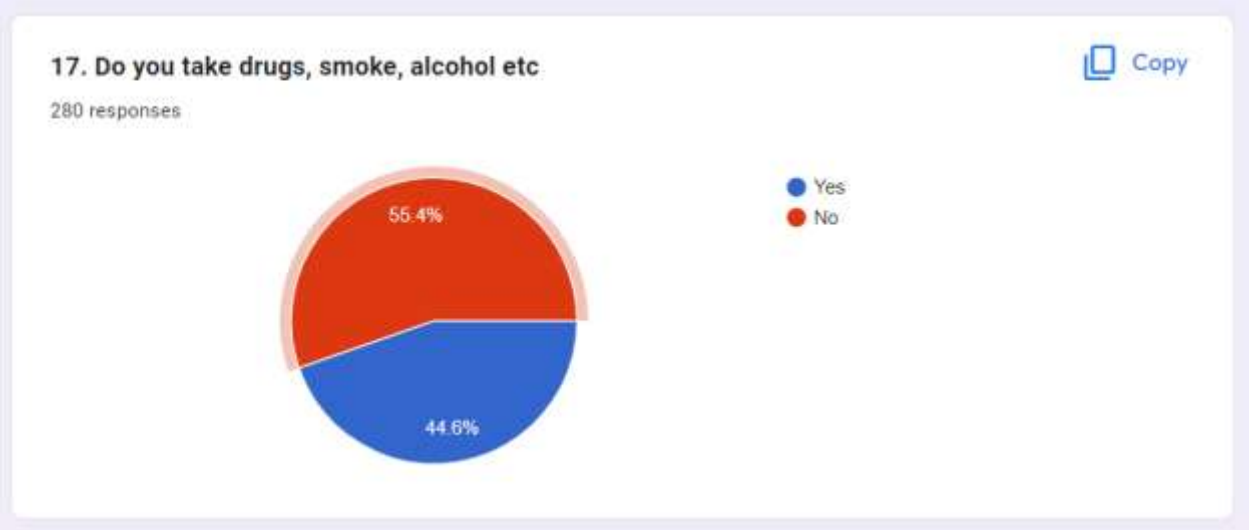


Figure 17: (Do you take drugs, smoke, alcohol etc)

Table 5

Do you take drugs, smoke, alcohol etc	YES	No	Total	p-value
	44	56	100	1.000
Total	**35**	**65**	**100**	

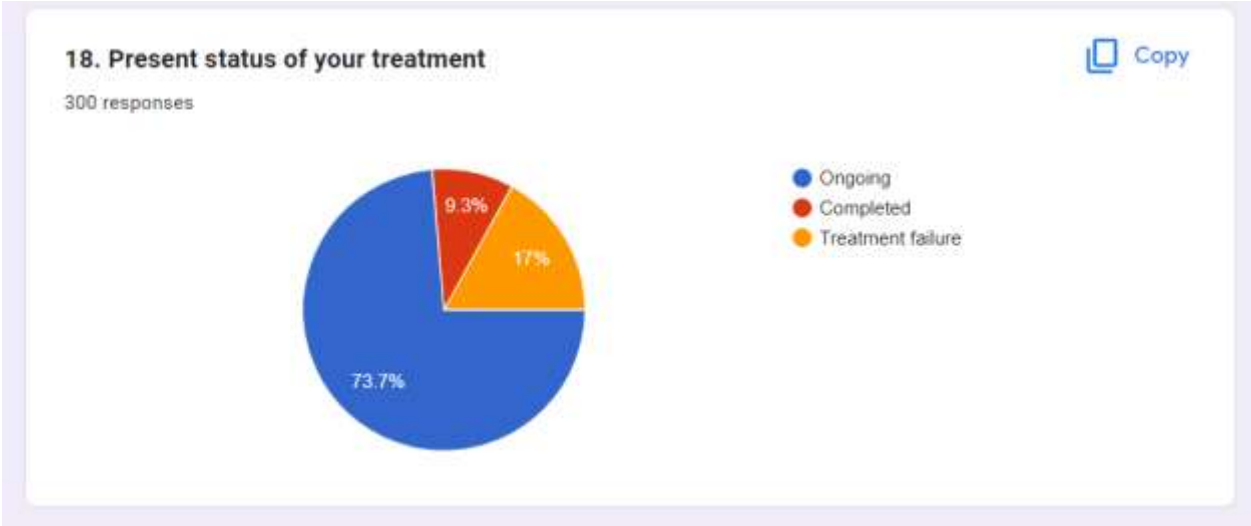


Figure 18: (Present status of your treatment)

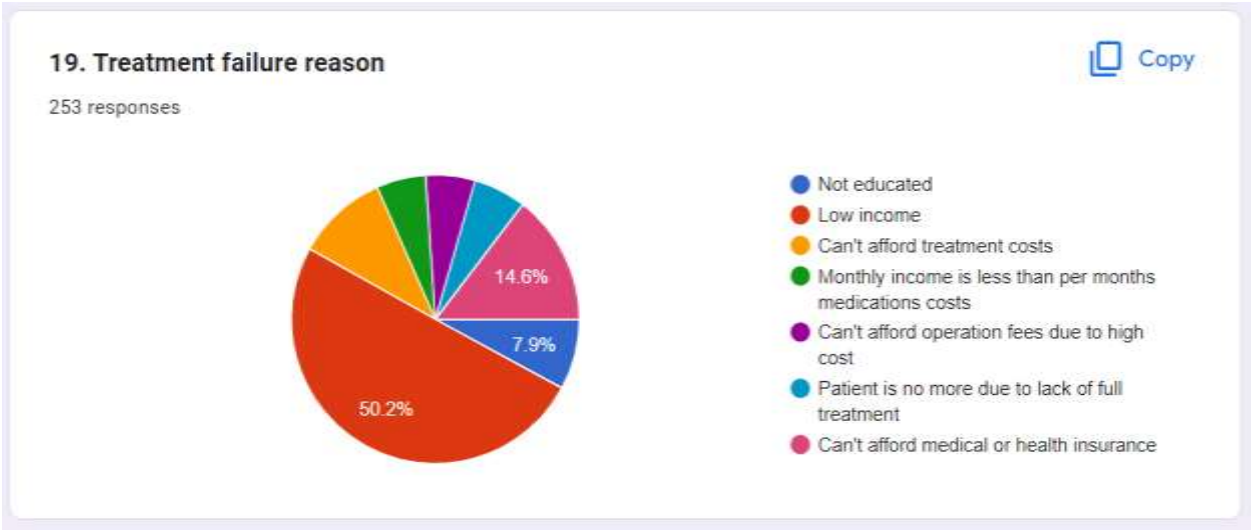


Figure 19: (Treatment failure reasons of Participants)

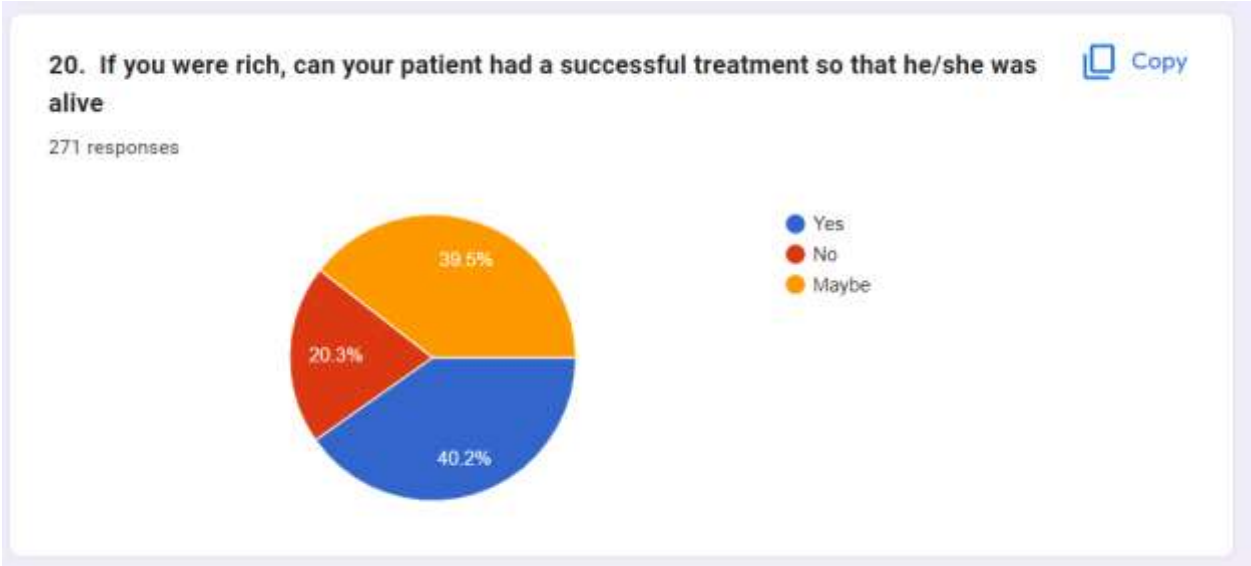


Figure 20: (If you were rich, can your patient had a successful treatment so that he/she was alive)

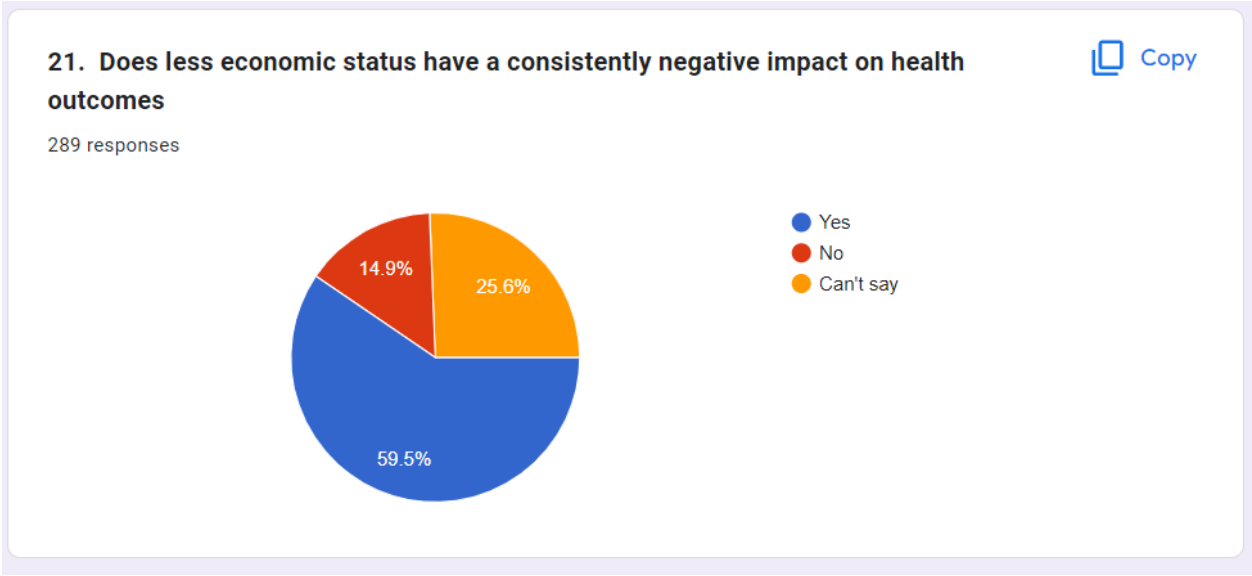


Figure 21: (Does less economic status have a consistently negative impact on health outcomes)

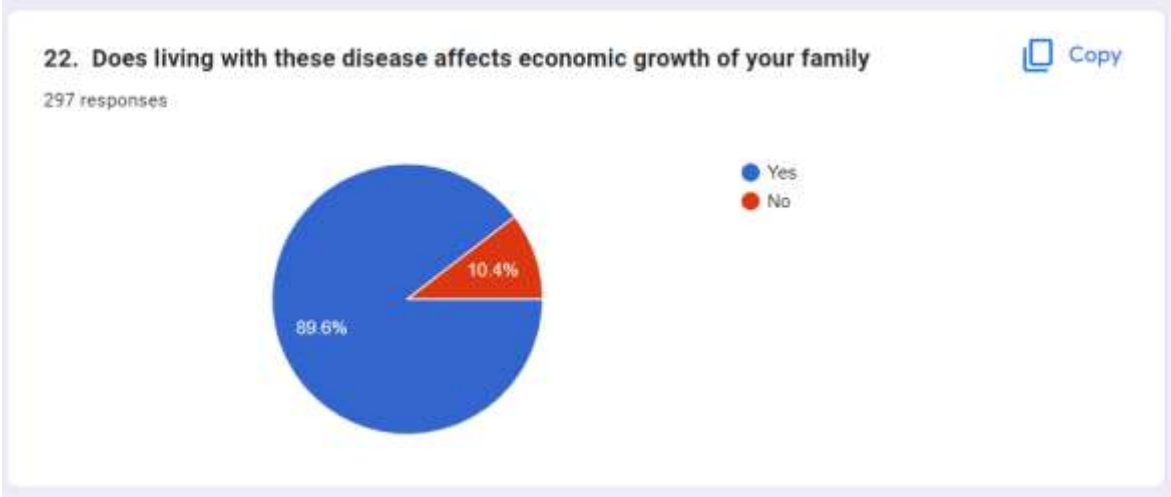


Figure 22: (Does living with these diseases affects economic growth of your family)

Table 6

Does living with these diseases affects economic growth of your family	YES	No	Total	p-value
	89	11	100	1.000
Total	**89**	**11**	**100**	

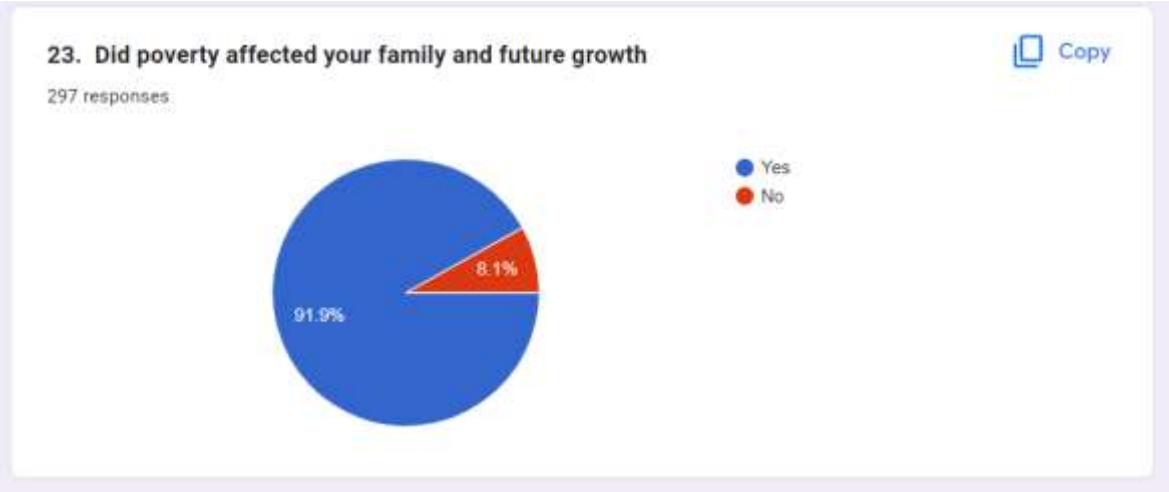


Figure 23: (Did poverty affected your family and future growth)

Table 7

Did poverty affected your family and future growth	YES	No	Total	p-value
	91	9	100	1.000
Total	**91**	**9**	**100**	

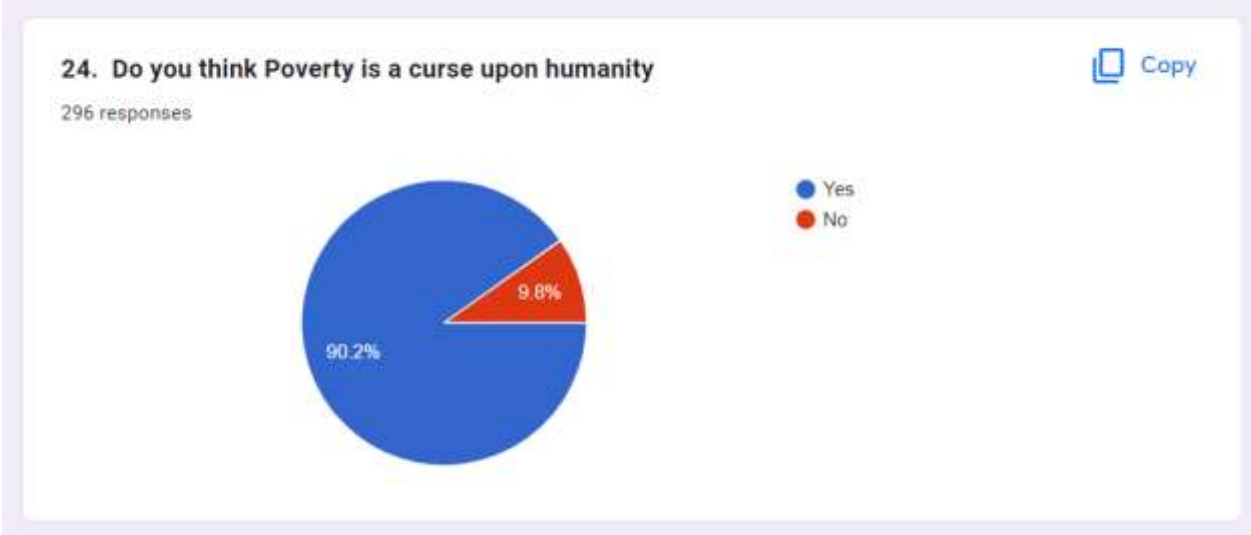


Figure 24: (Do you think poverty is a curse upon humanity)

Table 8

Do you think poverty is a curse upon humanity	YES	No	Total	p-value
	90	10	100	1.000
Total	**90**	**10**	**100**	

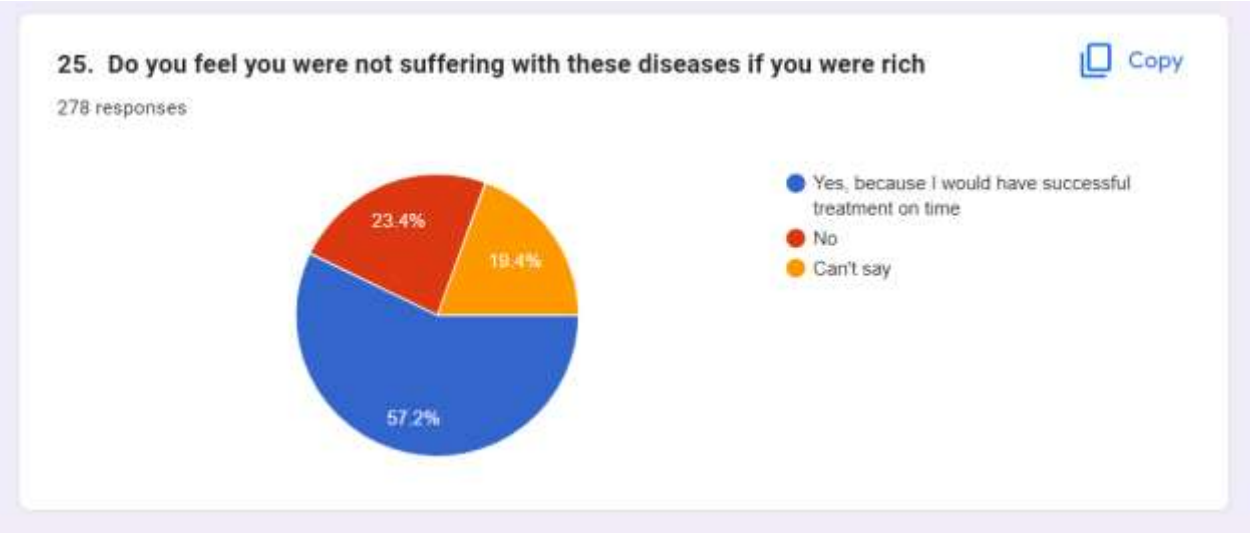


Figure 25: (Do you feel you were not suffering with these diseases if you were rich)

Summary

This chapter dealt with the statistical analysis and interpretation of data. The objectives of the study were attained through various statistical method and interpretation. The sample characteristics were dealt with frequency and percentage. Descriptive statistics were used to find mean and standard deviation. Inferential statistics was computed to find out the association. The results were discussed and interpreted in this chapter.

Discussion

This chapter discusses the major findings of the study and reviews that in relation to the findings from the results of the present studies. The aim of the study was to determine the connection between financial status and diseases. The findings of the study have been discussed as per the objectives along with findings of the other studies.

Conclusion

Poverty means not having enough to meet basic needs. The World Bank describes poverty as hunger, lack of shelter, lack of access to schools, and lack of healthcare. The World Bank estimates that in 2012 he was living on less than $1.90 a day for 896 million people. Most of the poor live in developing countries, where about 82% of the population lives in extreme poverty. The World Health Organization says poverty is bad for health because it forces people to live in polluted environments. In poverty-stricken countries, the poor suffer from disease.

The main and biggest causes of poverty in India are the country's high population growth. This leads to high illiteracy rates, inadequate medical facilities and lack of financial resources. Moreover, rapid population growth will affect and further reduce per capita income.

Poverty is a global, national and regional problem, but the impact at the local level is more devastating. Poverty causes disease, which creates poverty. A healthy person is better able to ensure the well-being of herself and her family, and vice versa. The causes of poverty are complex, but fighting them must be a priority. As such, international organizations and governments have put forward a long list of proposals and plans to try to reduce poverty. These include social security programs, improved education, debt

relief from developed countries for developing countries, the removal of import barriers to make it easier for countries with high poverty rates to sell their products, and affordable income for the poor includes income housing.

Furthermore, in 2000 the UN General Assembly set a target to be achieved by 2015. These include ending extreme poverty and hunger in the country, as well as widespread income inequality. Poverty reduction solutions must address the political, social and other factors that drive poverty. Poverty reduction at the national level requires community engagement at the grassroots level and cross-sectored cooperation in implementing poverty reduction programmers. Community involvement provides sustainability and boosts self-esteem and confidence. Poverty reduction improves the health of women and children and ultimately their living standards.

Poverty and diseases both can overlap to each other. Firstly we have to decrease the population and then we can control the poverty and also diseases when we all are educated and economically strong. If the most of the population of the country are educated and economically strong, the poverty and the diseases will be automatically reduced.

Findings, Recommendations & Implications

This chapter concludes the present study. The focus of the study was to determine the connection between financial status and diseases. This chapter deals with the findings and conclusions of the study. This chapter ends with suggestions and recommendations for research in future.

Major Findings

Poverty is the one of the major problem which totally affects the future growth of a family if anyone suffers with a major disease in the family.

Recommendations

On the basis of the present study, the following recommendations are formed for future study:

1. A study can be conducted to reduce the poverty level in the country.
2. A study can be conducted for the awareness of the diseases to the uneducated.
3. The study can be replicated on the larger sample and different cities to generalize the findings.
4. Cross sectional study can be done in different setting.

Summary

This chapter has dealt with the summary of the findings, implications of the study in the clinical research field and recommendation for the future.

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