

Available online at www.sciencedirect.com

Public Health

journal homepage: www.elsevier.com/puhe

Original Research

Health self-care in the United States

C.L. Shandra^{a,*}, N. Sonalkar^b^a State University of New York at Stony Brook, Department of Sociology/Program in Public Health, Stony Brook, NY, 11794-4356, USA^b State University of New York at Stony Brook, Program in Public Health, Stony Brook, NY, 11794, USA

ARTICLE INFO

Article history:

Received 25 February 2015

Received in revised form

9 October 2015

Accepted 28 February 2016

Available online 7 April 2016

Keywords:

Self-care

Time use

Social disparities

Disability

Health

ABSTRACT

Objectives: We provide the most recent population-level estimates of time spent in health self-care (including activities such as taking medicine, giving oneself an injection, and wound care). Additionally, we determine when, where, and with whom this time is distributed.

Study design: We analyze pooled cross-sectional data on individuals aged 21 years and older ($n = 36,033$) from the nationally representative 2008, 2010, and 2012–2013 American Time Use Survey.

Methods: We report the likelihood of any self-care, the mean minutes spent in self-care among those who report any, and the percentage distribution of self-care across the day, in the presence of others, and by place. We examine these trends overall and by sex, race/ethnicity, income, age, education, employment status, disability, and health.

Results: Overall, 6.7% of the population reports any health self-care on an average day, among whom an average of 76.6 min is spent in care. Individuals are most likely to report self-care in the morning, perform 76.1% of their care alone, and 97% in their own homes. These trends vary across sex, race/ethnicity, age, income, education, employment, disability, and health.

Conclusions: Our results demonstrate at the population level that self-care is a time-intensive form of health management that is not equally distributed by time, place, the availability of others, or by sociodemographic characteristics. It is important to consider these inequities in order to provide optimal support for patient care outside of health facilities.

© 2016 The Royal Society for Public Health. Published by Elsevier Ltd. All rights reserved.

Introduction

Patient-centered care has become an increasingly important tenet of health care delivery. While the Institute of Medicine first identified patient-centered care as a goal for the 21st century health care system¹ and more recently as a central

action for health care improvement,² the Affordable Care Act also incentivizes patient-centered care in an effort to reduce costs and improve primary care.³ One component of patient-centered care is health self-care,⁴ which involves a range of health promotion and treatment activities performed by the patient, often (but not always⁵) in coordination with and

* Corresponding author. Tel.: +1 (631) 632 7753; fax: +1 (631) 632 8203.

E-mail addresses: carrie.shandra@stonybrook.edu (C.L. Shandra), nikhilsonalkar@gmail.com (N. Sonalkar).
<http://dx.doi.org/10.1016/j.puhe.2016.02.030>

0033-3506/© 2016 The Royal Society for Public Health. Published by Elsevier Ltd. All rights reserved.

supported by a health care professional. For the broader population, self-care can entail disease prevention, treatment of minor ailments, routine physical and mental health maintenance, and self-evaluation. For patients with a disability or chronic illness, self-care may additionally involve rehabilitation practices, symptom management, and control of long-term conditions.⁵

But health self-care is not equally distributed across the population. Recent analyses of a unique nationally representative survey dataset, the 2003–2007 American Time Use Survey (ATUS),^{6,7} indicate that African Americans, older adults, and those with lower levels of income, education, and self-reported health were more likely to engage in health self-care than non-Hispanic whites, younger adults, and those with higher income, education, and health, respectively. This research indicates there are significant social disparities in participation in health self-care—defined in ATUS to include activities such as taking medicine, giving oneself an injection, and wound care.

However, less is known about more contemporary time allocation—or the context in which health self-care takes place. As time spent in health self-care can be considered both an investment in health capital⁸ and another form of patient ‘cost’,⁹ knowing when, where, and with whom health self-care occurs can also inform discussions of patient time management and the social supports available for adherence. For example, the presence of others during self-care may be necessary for people requiring physical assistance with the performance of self-care activities. It also signals the potential for social support, which positively associates with better and greater adherence to certain types of self-care.^{10–12} Location also matters. The household environment—unlike that of hospitals, clinics, or other health care facilities—is unstandardized, unregulated, and often inaccessible.¹³ Home-based self-care for treatment purposes necessitates appropriate patient education¹⁴ and medical devices to fit the patient's living space.¹³ Finally, the timing of self-care suggests how respondents allocate health commitments in tandem with the routines of everyday life, the scheduling of which may be constrained by other work and family commitments.^{15,16} To our knowledge, ATUS has yet to be used to explore these issues.

Therefore, we build upon previous analyses of health self-care^{6,7} by using a nationally representative sample of adults aged 21 years and older from the 2008, 2010, and 2012–2013 ATUS to examine the following questions: What is the likelihood of engaging in any health self-care on an average day? Among those who do report health self-care, what is the average amount of time spent? How is this time distributed across the day, with whom is it performed, and where is it performed? Finally, how do these trends vary by sex, race/ethnicity, income, age, education, health, and disability status?

Methods

The American Time Use Survey (ATUS) is a nationally representative survey sponsored by the US Bureau of Labor Statistics that collects information on daily time use.¹⁷ For the initial sample, respondents aged 15 years and over were

chosen randomly from households that had undergone their final interview for the Current Population Survey (CPS). This sample was then randomized by day such that half the respondents reported on a weekday and half reported on a weekend day, with sample weights later applied to correctly represent each day of the week. Computer-assisted telephone interviewing was used to ask respondents to provide demographic information, as well as a detailed account of their activities during a 24-hour period beginning at 4:00 am. The interviewer guided the respondent through their ‘diary day’, recording information such as start time and duration of each activity. Additionally, location and persons in the room with or accompanying the respondent were recorded on all types of activity categories except sleeping, grooming, and personal activities. Thus, the completed ‘diary day’ includes a full record of the respondent's activities and—for most types of activities—the context in which they took place. Full information about data collection and sampling is available elsewhere.¹⁸

The outcome of interest, health self-care (defined by ATUS as ‘health-related self-care’, code 010301), includes example activities such as: applying ointment, bandaging ankle, changing oxygen, doing childbirth exercises, doing stress management exercises, dressing a wound, exercising or therapy for medical reasons, gargling for sore throat, giving oneself a shot or injection, meditating (not religious), icing an injury, resting because of illness or injury, taking cough drops, taking insulin or medicine, taking vitamins, or testing blood sugar levels. Greater disaggregation of time use is not available in these data, although we follow previous studies^{6,7} in defining this measure. Fitness-related exercise (defined elsewhere in ATUS code 130000) is not included in our measure of health self-care.

Thus, ATUS allows us to examine the likelihood of reporting health self-care on an average day, the mean time spent in health self-care among those who do report time, and the distribution of this time across the day, with or without the presence of other people, and by location. To do this, we first construct a dichotomous indicator of whether or not the respondent reported any time in health self-care. This measure is used to calculate the percentage of the sample engaging in this activity. Then, among those who report any health self-care, we calculate mean minutes as well as several distributional measures. We explore what percentage of time is spent, hourly, among those reporting any hourly care. Next, we examine with whom self-care takes place, differentiating time spent alone from that spent with family, friends/acquaintances, strangers, or multiple combinations of those categories. Lastly, the distribution of time spent where includes time spent at home, in places that can be considered public in that they entail shared social environments (post office, gym, bank, library, school, store, grocery, worship, respondent's workplace), or in a private or other unspecified space (someone else's home, outdoors away from home, other or unspecified place).

We also explore how health self-care varies by socio-demographic characteristics, including sex, education, race/ethnicity, age, employment, and family income.¹⁹ While these indicators are available for all years of the survey, information on both health on diary day and disability is only included in

Download English Version:

<https://daneshyari.com/en/article/1313363>

Download Persian Version:

<https://daneshyari.com/article/1313363>

[Daneshyari.com](https://daneshyari.com)