



Health capabilities and diabetes self-management: The impact of economic, social, and cultural resources[☆]



Robert R. Weaver^{a,*}, Manon Lemonde^a, Naghmeh Payman^a, William M. Goodman^b

^a Faculty of Health Sciences, University of Ontario Institute of Technology, 2000 Simcoe Street N, Oshawa, Ontario L1H 7K4, Canada

^b Faculty of Business and IT, University of Ontario Institute of Technology, 2000 Simcoe Street N, Oshawa, Ontario L1H 7K4, Canada

ARTICLE INFO

Article history:

Available online 3 December 2013

Keywords:

Canada
Health capability
Economic inequality
Social support
Cultural capital
Diabetes self-management
Diet

ABSTRACT

While the “social determinants of health” view compels us to explore how social structures shape health outcomes, it often ignores the role individual agency plays. In contrast, approaches that focus on individual choice and personal responsibility for health often overlook the influence of social structures. Amartya Sen’s “capabilities” framework and its derivative the “health capabilities” (HC) approach attempts to accommodate both points of view, acknowledging that individuals function under social conditions over which they have little control, while also acting as agents in their own health and well-being. This paper explores how economic, social, and cultural resources shape the health capability of people with diabetes, focusing specifically on dietary practices. Health capability and agency are central to dietary practices, while also being shaped by immediate and broader social conditions that can generate habits and a lifestyle that constrain dietary behaviors. From January 2011 to December 2012, we interviewed 45 people with diabetes from a primary care clinic in Ontario (Canada) to examine how their economic, social, and cultural resources combine to influence dietary practices relative to their condition. We classified respondents into low, medium, and high resource groups based on economic circumstances, and compared how economic resources, social relationships, health-related knowledge and values combine to enhance or weaken health capability and dietary management. Economic, social, and cultural resources conspired to undermine dietary management among most in the low resource group, whereas social influences significantly influenced diet among many in the medium group. High resource respondents appeared most motivated to maintain a healthy diet, and also had the social and cultural resources to enable them to do so. Understanding the influence of all three types of resources is critical for constructing ways to enhance health capability, chronic disease self-management, and health.

© 2013 The Authors. Published by Elsevier Ltd. All rights reserved.

Introduction – The “health capabilities” (HC) approach

Health is shaped by the *chances* or opportunities people have to pursue health and to be healthy, along with the *choices* they make relative to these chances. Life chances are a function of the resources available to connect them to larger social structures. The association between access to resources and health outcomes is well-documented (Commission on Social Determinants of Health (CSDH), 2008; Department of Health and Social Security, 1980;

Humphries & van Doorslaer, 2000; Mackenbach, 2012; Marmot, 2005; Marmot et al., 1991, 2010; Phelan, Link, & Tehranifar, 2010; Rabi et al., 2006; Smith et al., 1990; Wilkinson & Pickett, 2006; Willson, 2009). These resources are more or less convertible to other resources that offer health benefits (e.g., fitness membership, healthy leisure activities, wholesome foods, high quality health care) and are unequally distributed across society. Greater access to resources means greater latitude in translating them into health-relevant resources to improve health and well-being.

The types of resources are varied as well. Economic resources often are viewed as most easily converted to other resources. Most obviously, economic capital and money can convert to other forms of private property. Over time, however, economic resources also enable attainment of educational credentials, broaden social networks, and expand lifestyle opportunities and choices available. These social and cultural resources, in turn, can be used to secure institutional positions and economic status. For instance, social ties can offer a person shelter, information, or the support needed to

[☆] This is an open-access article distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike License, which permits non-commercial use, distribution, and reproduction in any medium, provided the original author and source are credited.

* Corresponding author.

E-mail addresses: robert.weaver@uoit.ca (R.R. Weaver), manon.lemonde@uoit.ca (M. Lemonde), naghmeh.payman@uoit.ca (N. Payman), bill.goodman@uoit.ca (W.M. Goodman).

pursue health. Likewise, cultural resources – e.g., knowledge about health, the skills required to assess such knowledge, health-related values – also impact health and well-being. Economic, social, and cultural resources may coalesce and separate into social classes with distinctive lifestyles that serve to reinforce the social differences (Abel, 2008, 2012; Bourdieu, 1984, 1986; Cockerham, 2005). These distinctive ways of life, learned over the lifelong process of socialization, manifest in individuals' habits, preferences, and dispositions and influence health behaviors and health. Thus, an individual's lifestyle, health-related choices and behaviors remain "embedded in the structures of society" (Singh-Manoux & Marmot, 2005: 2130). Analysis of economic, social, and cultural circumstances within which individual "choices" are made offers a gateway for understanding the larger structures that shape them.

The health capabilities (HC) approach attempts to accommodate alternative viewpoints – one that sees health as a bi-product of a person's relationship to the social structures (life chances) and another that sees health as the outcome of voluntary choices made by autonomous individuals over a lifetime. The HC approach is derived from the more general "Capabilities Approach" suggested by Sen (1993, 1999), the conceptual and ethical underpinnings of which are discussed elsewhere (see Abel & Frohlich, 2012; Ruger, 2004, 2010a; Venkatapuram, 2011). As with capabilities theory, the HC approach is non-reductionist and application-oriented in viewing health and health capabilities as a function of choices made within a complex social and institutional context that also shapes these choices. By including individual choice and motivation within its framework it respects individual autonomy and agency, notions often left out of approaches that see health strictly as determined by resources or socio-economic status (Abel & Frohlich, 2012). At the same time, it recognizes the immediate and broader social context as a choice-shaping force, influencing a person's desires, values, and predilections over time through an ongoing process of socialization. Apart from presenting alternatives to choose from, the context offers an external presence that individuals must adapt to over time. In so doing, they develop "dispositions to act" (habitus) in certain ways, and to favor certain options over others (Bourdieu, 1984; Cockerham, 2005). Here, external structures become internalized and often become reproduced over time. By examining these relations, the HC approach seeks ways to alter the context to broaden the range of individuals' freedom, choice, and health capability.

Health capability and diabetes management

This investigation examines the health capabilities of people who suffer from diabetes. An exploration of how people with diabetes manage their condition elucidates several important elements of the HC approach. First, as with most conditions, the management of diabetes rests primarily on those who suffer from it. People with diabetes must substantially alter everyday habits to accommodate the disease, although the extent of change required may be greater for those from lower compared to upper class backgrounds (Lutfey & Freese, 2005). Health professionals will advise people with diabetes on how best to manage the condition, but everyday choices are considered the responsibility of the individual. For diabetes, this typically requires regularly monitoring glucose levels, controlling diet, and engaging in physical activity. It is, in the end, the "individual's choice" to do so. Yet, these choices are variously shaped by one's personal history and differently constrained by economic, social, and cultural circumstances: "Social positions are seen to create socialized dispositions" (Singh-Manoux & Marmot, 2005: 2130). Diabetes offers a clear instance where health achievement depends on the development of health agency – i.e., the "individual's ability to achieve health goals"

(Ruger, 2010b: 42). Second, the consequences of poor management are significant, involving myriad potential complications that, in turn, often compromise health capability. These include: cardiovascular, eye, and kidney diseases, stroke, neuropathy and complications of the extremities, mental illness and other conditions that severely diminish the quality of life and ultimately lead to premature death. When diabetes is well-managed, however, the onset of such complications often are delayed or prevented from arising altogether. Preventing avoidable morbidities and premature deaths are central priorities for the HC approach (Ruger, 2010a).

Finally, diabetes is common and is becoming more so. Worldwide, the number of people living with diabetes reached 347 million in 2008 – age-standardized prevalence was 9.8% for men and 9.2% for women – and is expected to grow in the decades to come (Danaei et al., 2011). In Canada, over 2.4 million (6.8%) currently live with diabetes, with millions more who remain undiagnosed (Centers for Disease Control and Prevention, 2011). The growing incidence of diabetes seems largely an outcome of unhealthy diets, physical inactivity, and an aging population (World Health Organization, 2011). Further, a disproportionate number of those afflicted are poor (Darmon & Drewnowski, 2008; Dinca-Panaitescu et al., 2011, 2012; Pilkington et al., 2010, 2011; Rabi et al., 2006; Raphael et al., 2011; Robbins, Vaccarino, Zhang, & Kasl, 2005; Saydah & Lochner, 2010), and those with insufficient resources likely face additional difficulties in managing their condition. Understanding how the social context and choices people with diabetes make within it can help inform initiatives designed to advance health capabilities and improved diabetes self-management.

Beginning from the left-most box, Fig. 1 suggests that economic resources can convert to social and cultural resources, and, in turn, social and cultural resources may translate into or reinforce economic resources. Over time, the three sorts of resources coalesce into a distinctive social class and associated "lifestyles" that are reproduced over time in individuals' lives through the process of socialization. This resource set ranges from low to high, and shapes a person's health capabilities.

Health agency operates in this middle box, impacting the health choices made that, in turn, impact health (depicted in the right-most box). Over time, one's health may shape one's health capability – good health helps sustain existing capabilities (enabling further health), while poor health cycles back to diminish health capabilities (which, in turn, may further exacerbate morbidities). For instance, healthiness and vigor will sustain or even advance the ability to be healthy. In contrast, co-morbidities often diminish the capacity to engage in physical activities, depression may dampen motivation to sustain current health, and both can lead to weight gain and worsening health. Poor health often can negatively affect economic, social, and cultural resources that can, potentially, diminish health capabilities further, creating a vicious circle. Genetic predilections, personality, the nature of health care systems also intervene to affect health capabilities, though the focus here is restricted to the impact of key resources embedded in the social structure – economic, social, and cultural resources.

Health capability and dietary management

We further limit our discussion to one key aspect of diabetes management – dietary habits. Diets can vary widely, and are very much produced by choices, that, nonetheless, become patterned over time within the confines of the larger social milieu – patterns that are difficult to alter. For instance, substantial research identifies the impact of economic resources on diet, whereby poverty or underemployment contributes to food insecurity, the risk of hunger, and a cycle of under- and over-consumption of what tends to be

Download English Version:

<https://daneshyari.com/en/article/7335985>

Download Persian Version:

<https://daneshyari.com/article/7335985>

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