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Spousal influence on mammography screening: A life course perspective

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ABSTRACT

Recently, researchers have challenged the basic tenet that marriage is universally protective for all individuals. We scrutinize socio-economic differences between married couples to shed light on the mechanisms underlying the effects of marriage. We introduce the life course perspective to investigate if differences in positive health behavior between couples are related to their early life conditions. Within the theoretical framework of cultural health capital, we hypothesize that the accumulation of cultural health capital proceeds at the marriage level when partners provide each other with health-related information and norms. For this purpose, we examine the influence of the childhood preventive health care behavior of both wives and husbands on the initiation of mammography screening for a sample of Belgian women ($N = 734$). Retrospective life histories of both partners are provided by the Survey of Health, Ageing and Retirement (SHARE) and are examined by means of event history analysis. The results show that a partner's cultural health capital affects the initiation of mammography screening by a woman in later life, even after her own cultural health capital and traditional measures of socio-economic status (SES) are taken into account. In line with cumulative advantage theory, it seems that inequalities in cultural health capital are accumulated at the marriage level. In order to shed further light on the spousal influence on health behavior, researchers should revert to early life in order to discern the attribution of premarital and marital conditions.

Introduction

Research on the determinants of (preventive) health care use has traditionally concentrated on disparities related to individual characteristics. A need-adjusted approach based on Andersen's heuristic model of health services use (1995) is generally adopted when considering how health care use is the consequence of individual need, socio-economic and demographic characteristics, and individual health beliefs (Hanratty, Zhang, & Whitehead, 2007; van Doorslaer, Masseria, & Koolman, 2006; Wagstaff & van Doorslaer, 2000). However, the lives of individuals do not run in isolation, but interdependently (Elder, Johnson, & Crosnoe, 2003). Therefore, seeking professional care is often not the result of an individual decision, but of an interactive process (Pescosolido, 1992). The ways in which social ties affect health behavior are central in models that seek to explain the well-established positive effect of social ties on health (House, Landis, & Umberson, 1988; Umberson, Crosnoe, & Reczek, 2010; Umberson & Montez, 2010). Predominantly, researchers have focused on the beneficial effects of marriage (House et al., 1988; Martikainen, Martelin, Nihtila, Majamaa, & Koskinen, 2005; Umberson et al., 2010; Umberson & Montez, 2010). It is argued that marriage instills norms and a sense of obligation around responsibility for family members (Thomas, 2011; Umberson, 1987; Waite, 1995), inhibiting risky behaviors (Berkman & Breslow, 1983; Chilcoat & Breslau, 1996; Duncan, Wilkerson, & England, 2006; Liang & Chikritzhs, 2012; Staff et al., 2010) and promoting more positive health behaviors (Osler, McGue, Lund, & Christensen, 2008; Wang et al., 2011; Wilson, 2002). However, the mechanisms underlying the positive health behaviors of married individuals are poorly understood and interventions that involve the partners' influence on health promotion seem unsuccessful (Black, Gleser, & Kooyers, 1990; Lewis et al., 2006; Lichtenstein & Glasgow, 1992). Hence, in the past decade, researchers have challenged the contention that marriage

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is universally protective for all people and all health outcomes (Carr & Springer, 2010). New insights could be gained by scrutinizing if and how the presumed beneficial health effect of marriage differs among socio-economic groups. It is somewhat surprising that socio-economic differences between partners are largely ignored, given the well-established social gradient in health (Mackenbach et al., 2008; Marmot et al., 1991; Robert & House, 2000) and health behavior (Lynch, Kaplan, & Salonen, 1997; Puddu, Demarest, & Tafforeau, 2009; Stringhini et al., 2010).

The discussion is hindered by the use of cross-sectional designs, amongst others. These widely-used designs make it impossible to discern to what extent the effects attributed to marriage can also be ascribed to premarital health habits and premarital socio-economic conditions (Meyler, Stimpson, & Peek, 2007). Individual lives are not unwritten pages at the time of marriage. Just as lives are lived interdependently, they are also imbedded in a personal life course. Recent longitudinal studies have shown that premarital health behavior influences substance use later in life (Homish, Leonard, Kozlowski, & Cornelius, 2009), as well as drinking (Leonard & Das Eiden, 1999; Leonard & Mudar, 2003), regular exercise, routine physical examinations, and healthy eating (Homish & Leonard, 2008). In these studies, premarital health behavior is assessed immediately prior to marriage, at the time of applying for a marriage license. However, we should revert to conditions earlier in life in order to understand the development of health behavior throughout an individual's life. Life course researchers urge giving consideration to the dynamic nature of social ties and health behavior (Thomas, 2011; Umberson et al., 2010). Although marital partners are the most important and powerful source of influence in a person's adult life, parents are predominant during childhood (Umberson, 1992). Socialization into healthy behaviors start when children observe and learn their parents' attitudes, beliefs, and values on health behavior (Cardol et al., 2005; Uhlenberg & Mueller, 2003) and the process continues throughout adult life, as proposed by health-related social control theory (Lewis & Butterfield, 2007).

The life course perspective has recently established a central position in public health research (Due et al., 2011). Mounting evidence demonstrates that the childhood socio-economic position exerts long-term influences on health-related behavior in later life (Kuh, Power, Blane, & Bartley, 2004), for example for alcohol consumption (Lynch et al., 1997; Poulton et al., 2002), physical activity (Lynch et al., 1997; van de Mheen, Stronks, Looman, & Mackenbach, 1998), obesity (Lynch et al., 1997; Power et al., 2005), oral health (Poulton et al., 2002; Thomson et al., 2004), and dental service use (Peres, Peres, de Barros, & Victora, 2007). Social homogamy might even further amplify these antecedent individual differences (Monden, 2007). On the one hand, direct assortative mating may occur, when a partner is selected on the basis of a common healthy lifestyle. On the other hand, and more likely, similarities in healthy behavior between partners may be an indirect consequence of partner selection based on other socio-economic or cultural resources (Falba & Sindelar, 2008; Monden, 2007). Given the importance of education in influencing health behavior (Mirowsky & Ross, 2003), and preventive health care use in particular (Puddu et al., 2009; Stirbu, Kunst, Mielck, & Mackenbach, 2007), the well-documented tendency toward educational homogamy (Blackwell, 1998; Kalmijn, 1998; Smith & Christakis, 2008; Smits, Ultee, & Lammers, 2000) may play a crucial role.

By analogy, cultural health capital theorists have recently subscribed to a longer-term view of an individuals' life, when elaborating on how cultural health capital develops. They have argued that the health-relevant knowledge and skills used to lead healthy lives, start accumulating in childhood and this proceeds over the life course through repeated contacts with health care providers and lifelong socialization (Abel & Frohlich, 2012; Mirowsky & Ross, 2003; Shim, 2010). At the time of marriage, individuals have already gained a certain degree of cultural health capital, which is likely to impact not only on their own health behavior, but also on that of their partner. Given the aforementioned tendency to marry similar others in terms of socio-economic position or cultural resources (Kalmijn, 1998), cultural health capital can accumulate at the marriage level. Therefore, assortative mating can produce cumulative life course advantages or disadvantages (DiPrete & Eirich, 2006; Willson, Shuey, & Elder, 2007), which could be greater at the household level than at the individual level (Monden, 2007).

The Survey of Health Ageing and Retirement (SHARE) enables empirical exploration for the first time of how cultural health capital accumulates at the marriage level, by providing data that is both dyadic and longitudinal. The aim of this paper is to investigate within a life course framework how women's preventive health care behavior in later life is influenced not only by their own cultural health capital, but also by that of their partner. Therefore, the influence of childhood and adult preventive health care behavior of both partners on the initiation of mammography screening will be investigated for a sample of women in Belgium. The rationale behind the choice of mammography screening is twofold. First, the link between cultural health capital and healthy lifestyles is clearer in the case of preventive health care, where ill health is not the major driving force behind engagements with health care providers. Second, breast cancer constitutes a major public health issue, as it is the most frequently diagnosed cancer among women worldwide (WHO, 2012), including in Belgium (Puddu et al., 2009). Mammography screening is the only option for detecting breast cancer at an early stage (Palencia et al., 2010; Puddu et al., 2009). Yet, despite recommendations by the World Health Organization (WHO, 2012) and the European Union (OJ C 68E, 2004), not all women engage in mammography screening, and socio-economic inequalities in the take up of screening seem to persist (Duport & Ancelle-Park, 2006; Jusot, Or, & Sirven, 2011; Lagerlund et al., 2002; Lorant, Boland, Humblet, & Deliege, 2002; Puddu et al., 2009; Zackrisson, Lindstrom, Moghaddassi, Andersson, & Janzon, 2007).

Theoretical framework: cultural health capital

The concept of cultural health capital (Abel & Frohlich, 2012; Shim, 2010) has been developed to move toward a more neo-structural approach to explain socio-economic inequalities in (preventive) health care. It draws on Weber's description of lifestyle as a collective social phenomenon (Weber, 1922, 1978) and Bourdieu's elaboration, as well as his conversion capital hypotheses (Bourdieu, 1986), to explain how economic and cultural capital can be transformed into cultural health capital (Abel & Frohlich, 2012; Shim, 2010). The latter can be defined as 'comprising all culture-based resources that are available to people for acting in favor of their health' (Abel, 2008, p. 2), such as engaging in preventive care (Abel, 2008; Abel & Frohlich, 2012; Phelan, Link, Diez-Roux, Kawachi, & Levin, 2004; Shim, 2010; Veenstra, 2007). Examples are knowledge of medical topics and vocabulary, instrumental attitude toward the body, self-discipline, orientation toward the future, etc. (Shim, 2010). Cultural health capital is not a fixed entity, but develops and accumulates over the life course and is shaped by socio-economic conditions (Abel & Frohlich, 2012; Mirowsky & Ross, 2003; Shim, 2010). The accumulation starts early in life and might then continue at the marriage level, when partners provide each other with information and norms on health behavior (Thomas, 2011). Therefore, it can be expected that (un)favorable socio-economic conditions of both partners in childhood will impact on health behavior in later life. Assortative mating can exacerbate these effects and generate systematic divergences over the life course, as contented by cumulative advantage theory