Introduction

It is well established that racial and ethnic minorities experience preventable chronic diseases in the United States at a higher and substantial rate. Despite the fact that few health, many people do not have the disease awareness necessary to prevent it. However, for many, it is the fear of not having health insurance and the access to health care that is the problem. Rogers has proposed “health capability” framework, which aims to measure opportunity for healthy living. Capabilities include neighborhood resources, a supportive social environment, good physical functioning, knowledge of what to do, and time to do it. Research shows that the affordability of health insurance matters most. In this study, we investigated the deepening in which increased access to more beneficial outcomes. Additionally, we examined the number of communities with health capability at a higher level of income.

Materials and Methods

Participants: We recruited participants from the clinical sites of the Residency Research Network of Texas, a collaboration of family medicine residency programs. Eligibility criteria included adults aged 18-74 who spoke English or Spanish.

Procedure: Medical students research assistants approached 859 patients as they waited for their office visit, and invited them to complete a self-report questionnaire. 622 patients completed surveys, for a participation rate of 73%.

Measures: The 18-item patient survey included information about physical, mental, social, diet, physical activity, loss of control, literacy, and patient demographics, including gender, age, income, education, insurance status and preferred language. The concept of “opportunities for healthy behaviors” was measured with a scale. Capabilities: We measured for Diet and Activity (CADA), a 13-item measure with subscales: Consequence, Barriers, Knowledge, Support of Family, and Specific, Opinion, Opportunity, Time, and Respect. Each scale was measured on a 5-point scale, with higher scores indicating stronger capability.

Results

Of our sample, 51.3% were female and 49.0% were married. The participants predominantly Hispanic at 51.5% with an average age of 44.1 years. The incomes between patients were fairly evenly distributed with 51.2% having less than $36,000 dollars per year, 27.0% making between $36,000 and $51,999, 15.6% making between $52,000 and $75,000, and 6.1% making $75,000 or more. In Figure 1, all of the CADA variables except Time for and Respect demonstrated a significant correlation with income (p<.05). Additionally, Figure 3 displays the correlation between income and capability among our sites.

Key Terms

Convenience F: Healthy food is available and affordable.

Convenience PA: There are places in your neighborhood available for physical activity.

Barrier F: Barriers prevent me from preparing healthy meals.

Barrier PA: Barriers prevent me from engaging in physical activity.

Knowledge: I know how to live a healthy lifestyle.

Opportunity: My neighborhood provides walk, all in areas for physical activity.

Support: My spouse, family and friends support healthy habits.

Time F: I have time to prepare healthy food.

Time PA: I have time to engage in physical activity.

Respect: I feel respected by society.

Conclusions

Figure 2 supports prior studies, displaying that an increase in income is significantly correlated with an increase in capability. All of the CADA correlations with income except Time for and Respect are significant. This finding suggests that across all income levels there is equal time (or lack thereof) to shop for healthy foods and prepare nutritious meals. Some of the lowest CADA scores were in barrier to physical activity and time for physical activity. These two areas can be focused on during patient interviews to start discussions on what people can change about their lifestyles so that they are physically capable of being active.

Figure 3 exhibits the steepest decline in CADA variables’ correlations with income. In this case a significant correlation means that the participants who see the most capable are those with the highest incomes. San Antonio and Austin share some of the highest correlation between capabilities and income among white and non-white. The color income profile could be attributed to the layout of the three cities. In that neighborhood, there is an increasing trend in income and opportunity for higher socioeconomic classes. A recent study by the Pew Research Center further supports our findings stating that “higher income people in San Antonio are more likely to live amongst wealthy whites in any other major U.S. metropolitan area.” The extreme barrier consequence is likely because Austin demotes a city where income, education, and opportunity are more evenly distributed allowing people to find specific areas of focus when addressing a lifestyle change based on a patient’s city of residence and income.

References


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