

# [Research t2d development. many communities lack healthy](https://assignbuster.com/research-t2d-development-many-communities-lack-healthy/)

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Research on theprevention and management of type II diabetes (T2D) in America hastraditionally centered around biomedical, pathophysiological, and lifestylefactors. Hepatic glucose overproduction and a lack of physical activity, forinstance, have been well-studied as both risk factors for the disease andpotential treatment targets (Cornell, 2015). More recently, however, researchhas recognized the need to more closely examine the role of the socialdeterminants of health in T2D prevention and management.

On the most basiclevel, these determinants can impact the behaviors related to the developmentand progression of the disease. More significantly, however, research suggeststhat these determinants can impact the incidence and prevalence of the diseasedirectly via complex physiological, social, and psychological avenues (Clark, 2014). Although researchersare continuing to unearth new correlations between various social factors andT2D, evidence strongly suggests that three broad categories of thesedeterminants are especially central to the development of the disease: one’s neighborhoodand built environment, economic stability, and ability to access quality healthcare (Clark, 2014). Preliminary findings have suggested that other socialdeterminants such as education level and social and community support may alsoplay a role in T2D development, but further research needs to be conducted inorder to make stronger conclusions about these factors (Hyman et al., 2017). The quality of one’sneighborhood and built environment appears to be a strong predictor of T2Ddevelopment. In many rural and urban communities with inadequate socioeconomicand political infrastructures, residents face various significant barriers tohealthy living and T2D prevention. A lack of transportation makes it almostunfeasible for many individuals to access goods and services like quality food, educational resources, and opportunities for physical activity (Hill et al.

, 2013). This transportation-mediated material deprivation has been shown tocorrelate significantly with T2D incidence. Such a lack of transportation canalso severely impede access to healthcare, and pre-diabetic symptoms and thelifestyle habits that contribute to them can hence progress largely unchecked (Hill, Nielsen, & Fox, 2013). Food insecurity – acondition wrought by a combination of many social factors including the qualityof one’s environment – has also garnered special attention as a key contributorto T2D development. Many communities lack healthy food options altogether, andothers make it difficult for residents to access healthy food due to inadequatetransportation systems.

To this end, food-insecure households have been shownto be at an almost 50% greater risk for developing T2D than food-securehouseholds (Gucciardi et al., 2014). A lack ofneighborhood safety has also been shown to contribute significantly to thedevelopment of T2D. Evidence has strongly indicated one plausible pathwaythrough which this effect is mediated; communities with high crime rates oftenhave a depleted employment, business, and recreational infrastructure, whichcan lead to a reduction in the availability of many health-promoting goods andservices (Clark, 2014).

As a whole, then, it would appear that one’sneighborhood and environment strongly impacts his or her risk for developingT2D through a variety of complex pathways. In addition to neighborhoodand environmental factors, economic stability has been documented as a strong riskfactor for T2D. Studies have repeatedly suggested that T2D incidence issocioeconomically graded, especially with respect to income. For instance, menin the lowest income category in the U. S. have been shown to exhibit an almosttwofold greater risk of developing T2D than those in the highest income bracketwhen controlling for such factors as exercise habits, weight, and literacy(Hill, Nielsen, & Fox, 2013). Similar significant correlations have beenobserved between an increased risk for T2D and other economic factors likeemployment status, immigration status, and housing quality (Hill et al.

, 2013). Plausible explanations for these associations have centered on disadvantagedindividuals’ limited ability to afford healthy food and insurance and thepossible psychological and biological effects of chronic stress on theseindividuals (Walker, Smalls, & Egede, 2015). A wealth of researchhas also demonstrated that health care and health care access are crucialdeterminants of T2D development. Many residents in low-SES communities facelimitations in the access to and/or availability of quality medical resourcesand services.

These areas often do not have the resources to provide primary orspecialty care for residents, and this has been shown to result in theunmitigated progression of pre-diabetic symptoms and maladaptive lifestylehabits in residents (Hill et al., 2013). Even in areas with access to care, poorquality of care can increase the risk for T2D. For instance, poorphysician-patient interactions, influenced by factors like a lack of culturalcompetence, have been linked to an increased risk of T2D development inpatients (Hyman et al., 2017). Although there is extensiveresearch focusing on how social determinants affect the development of T2D, there is comparatively less research examining how these determinants directlyaffect the health outcomes of patients already living with the disease. Hence, this is an area that warrants much future research and inquiry (Hill, Nielsen,& Fox, 2013). Evidence does, however, point to a great degree of overlap inhow social factors impact the basic experiences of individuals at risk for andsuffering from T2D.

Certain social determinants can greatly increase the riskof individuals developing T2D through specific pathways, and if theseindividuals fully develop the disease, these factors are thought to contributeto adverse health outcomes through these same pathways (Clark, 2014). Forinstance, a lack of health care access appears to adversely impact theexperience of T2D patients much in the same way it poses a risk to prediabeticindividuals. Patients in areas without primary or specialty care access reportworse symptom management and glycemic control just as prediabetic individualsin similar areas report worse symptom progression (Walker, Smalls, & Egede, 2015). In addition to theevidence implicating social factors in the development and management of T2D, agrowing realization of the inability of current care models to address thesefactors has spurred recommendations for population-level interventionsspecifically targeting the social determinants of health. Traditional treatmentmethods for T2D have typically focused on clinical strategies aimed at reducingsymptoms through medication regimens and behavioral changes.

These strategies, however, have been limited in their inability to account for other non-medicalinfluences on patient behaviors (Hyman et al., 2017). By tackling factors likeemployment insecurity, low-income status, and low health care literacy at thepolicy level, researchers hope that there can be a more sustainable means forimpeding high American T2D incidences (Clark, 2014). A main focus of thisreform is aimed at conducting further research and collecting more data onnon-medical factors affecting T2D incidence and progression at the populationlevel. This would, in turn, help shape policies and therapeutic interventionsto better address the disease. A primary target for this effort is theAffordable Care Act (ACA). Researchers have called for the expansion of theACA’s standardized collection of population data to offer a more comprehensivepicture of non-medical social determinants (Hill et al., 2013).

At thepopulation level, this would allow providers to visualize certain social trendsconcurrently with the development of diabetes in high-risk communities. Thus, they would be able to make quick, evidence-based clinical decisions forpatients in real time based on the specific social challenges they face (Hill, Nielsen, & Fox, 2015). Enabling morecomprehensive data collection would also allow healthcare systems to implementspecific community level interventions for high-risk populations. For instance, health systems and civic structures can use data to proactively discernspecific groups at risk for T2D that would especially benefit from newcommunity resources such as affordable food markets, community health workers, and accessible transportation options (Hill, Nielsen, & Fox, 2013).

Theimplementation of these resources would undoubtedly be costly, however, and theimmediate financial cost would appear to be a significant limiting factor forthis policy-level reform (Walker, Smalls, & Egede, 2015). Althoughpreliminary studies have indicated that these reforms are better suited tosustainably treat T2D, further research would need to be conducted to elucidateat least two key understandings before widespread change can be enacted: howspecific health interventions might directly impact health outcomes fordiabetic and pre-diabetic patients and how these interventions can be enactedin a cost-efficient manner (Hill et al., 2013).