Published in final edited form as:

Pract Anthropol. 2016 ; 38(2): 15–17. doi:10.17730/0888-4552-38.2.15.

Anthropologists address health equity: recognizing barriers to care

Abstract

Systems change is necessary for improving health care in the United States, especially for populations suffering from health disparities. Theoretical and methodological contributions of anthropology to health care design and delivery can inform systems change by providing a window into provider and patient perceptions and practices. Our community-engaged research teams conduct in-depth investigations of provider perceptions of patients, often uncovering gaps between patient and provider perceptions resulting in the degradation of health equity. We present examples of projects where collaborations between anthropologists and health professionals resulted in actionable data on functioning and malfunctioning systemic momentum toward efforts to eliminate disparities and support wellness.

Background

Health Resilience Among American Indians in Arizona is a community-engaged pilot research project funded by the National Institutes of Health (NIH) National Institute on Minority Health and Health Disparities (NIMHD) under the umbrella of the Center for American Indian Resilience (CAIR). Researchers on *Health Disparities* developed a proposal based on previous community-engaged studies on the role of providers in deterring weight-related childhood health problems in Arizona funded by the Kresge Foundation's Safety Net Enhancement Initiative (SNEI). Community researchers found that healthcare providers conceptualized obesity as a problematic health condition, rife with risk for comorbidities such as type II diabetes, cardiovascular disease, and cancer, with an early death as the likely result. Non-healthcare providers, on the other hand, associated obesity with laziness, the absence of friends and family, poor habits, or lack of self-control. Researchers used interviews including an activity whereby participants who did not work in healthcare drew pictures of a healthy body and an unhealthy body to investigate perceptions of weight-related health disparities. In drawings of healthy bodies research participants depicted people holding hands with friends and family, playing sports, and walking in nature. Unhealthy bodies included isolated and inactive individuals eating junk food. In accompanying interviews participants discussed “obesity” as a term that indicated laziness, lack of moral character, and disconnection with others. Given the complexity of findings regarding sociocultural constructions of bodies and obesity, leaders of this early project quickly changed the project name from one that was based on childhood obesity, to a much more anthropologically-grounded and broadly-focused name based on the intricacies of health and wellness, and barriers to care: *A Beautiful Life / Hermosa Vida / Nozhoni ilna*.

Embedded within healthcare provider research results were explicitly stated beliefs that patients lacked information and motivation to change weight-related health problems. Patient data told a different story, however: one in which patients knew well what to eat and

how to change their lives to become healthier, though often lacked the time and resources to do so. Overall results revealed a need for further research, documentation, and dissemination of the gaps between healthcare provider and patient perceptions with regard to health and wellness.

An anthropologist and public health scholar partnered to further investigate differences in perspective of providers and patients with a focus on health disparities among American Indians living off-reservation in Arizona. Instead of focusing on the deficiencies of patient knowledge, researchers sought to examine the ways in which patients developed strategies for resilience.

Researchers used the principles of Community-based Participatory Research (CBPR) and methods of Rapid Assessment, Response, and Evaluation (RARE), an ethnographically driven mixed methods research toolkit to address research objectives. A group of community researchers collaborated in training in RARE methods, developed research foci, and participated in data collection analysis and dissemination. During the first days of the project, the team developed their operational definition of resilience as an ability to achieve and maintain health and wellness in light of immense struggles related to racism, historical and present violence, poverty, access to care, food insecurity, and severe health disparities. The inclusion of recognizing hardship within the definition was particularly important in light of the past and present struggles of American Indians who have endured a history of systematic genocidal policies including violent relocation, forced removal of children, and ongoing inequalities. A symbol of resilience in this project, drawn by a young Navajo member of the research team, became a picture of a flower growing through broken concrete.

Results indicated patterns in training and positioning of healthcare providers as a key component in both the lack of communication in clinical settings and the barriers to quality care experienced by patients. We argue that a deeper understanding of these perspectives and miscommunications could guide changes in medical systems in a time when care beyond the walls of clinics and hospitals is desperately needed.

Provider participation

Through an engaged and collaborative process our research team for *Health Resilience* identified two designated groups of people charged with providing medical care to patients: medical doctors, doctors of osteopathy, and nurse practitioners in one group and physical therapists, nutritionists, medical assistants, and others in the other group. We identified the first group as “healthcare providers” and the second group as “support providers.” Both groups played important roles in health communication. Each provider participant spoke with a researcher for 1–2 hours in a semi-structured interview. Interviews included information on perceptions of health and the body, wellness, resilience, and patient care specific to American Indians. We also conducted interviews, Wellness Mapping (Hardy et al., 2014) activities, and focus groups with American Indian people who self-identified as “resilient” using a collaboratively defined screening instrument.

Systems change

Health Resilience research is particularly relevant during a time when there is national focus on the need to address social determinants of health through new systems in home health care and clinic outreach. Hospitals across the country are withstanding heavy fines due to re-admittance of patients upon discharge from the hospital, leading to unnecessary visits to emergency care facilities after even routine surgeries. In response to these challenges, teams of multifaceted professionals continue to develop innovative projects with the goal of working toward the dissolution of patient-side barriers such as lack of reliable transportation to medical appointments. People working with these programs, though, often encounter structural challenges such as lack of funding or supporting infrastructure for needs that fall outside of a limited definition of health care within existing systems. Lack of cohesion on best practices for such programs leaves large holes in a safety net for people who suffer from the intersecting dimensions of inequities in health and overall survival.

Barriers to care

Barriers to care are often construed as failures of patients, despite well-meaning intentions. Programs designed to increase “cultural competency” sometimes frame the foundation of inequity as patient inability to speak and understand English fluently, or lack of education limiting patient comprehension of basic directions. In our research, however, we found that barriers to effective communication and care often originate within vast differences between physician and patient communication. Not only did patients misunderstand instructions at times, providers also inaccurately assumed patient inability to understand and withheld information or communicated information in ineffective ways. One illustrative example in our project was the perspective and practice of a provider who stated that Native patients did not have the capacity to understand directions, and as a result he would only tell them to “take this medicine and if it doesn't work call this number.” Our results indicate that barriers to care could be improved with a shift in focus from patient deficiencies to provider responsibility to ensure patient understanding. Different and more intense trainings for healthcare professionals may be one way of broadly implementing this change.

Provider perceptions

Anthropologists continue to study the differences between how people understand bodies, systems, health, and illness based on geographic and temporal differences among others. Researchers such as Merrill Singer, Paul Farmer, Emily Martin, Leslie Sharp, and others write about the relationship between perceptions of bodies and larger political-economic systems. Michel Foucault wrote of the contribution of the rise of expertise in the medical field in widening the distance between providers and patients. While providers may no longer engage in the rituals of the past, there are still underlying assumptions about bodies that clearly arise in reported practice through interviews and other forms of research, and that indicate ruptures in the needed trust that must occur for health care provider work to be most successful for patients in need. It is within the analysis of underlying assumptions, embedded in medical training across expertise that social scientists may continue to contribute to changes in medical care and the reduction of health disparities.

Patient resilience / Provider connections

When discussing resilience in interviews, American Indian participants in *Health Resilience* indicated the value of close relationships with health care providers who took time to get to know them and find out what was going on in their lives. Providers who “do the leg work” for patients are those that participants acknowledged as change agents in supporting healthy, even life altering choices for their patients. Providers who were more immersed in the communities of their patients, those who had either lived on or served reservation communities directly, had more in-depth understandings of their patients; however, even those providers would occasionally make statements about the passivity of bodies and patients.

Passivity of bodies is also intertwined in the marketing of medical procedures, as we documented at a bariatric surgery presentation during the research period. During a presentation about the surgery, which is sometimes life threatening and can have serious side effects, one physician cited an article from the early 90s appearing in a well-known medical journal stating that only a small percentage of people change their BMI without surgical interventions. Presenters continued on to explain to all providers in attendance that bariatric surgery was the only option for most people to reduce their weight since motivations, behaviors, and abilities were apparently absent.

Individual responsibility

While there was a continuum in provider understandings regarding health inequity and patient resilience, many providers paid minimal or no attention to systematic barriers that patients faced and instead focused on the individual's role in wellness in interview discussions. The majority of healthcare providers and support providers reported in interviews that their clinical communication strategies focused on the assessment of individual patient motivation before coming up with strategies to promote healthy change. Many providers expressed enthusiasm for helping “motivated” patients to make healthy changes and frustration in having to deal with less inspired patients. The latter patients were understood by providers to be individuals who took no interest in their health and possessed no desire to change. In particular, support providers, such as diabetes educators and fitness specialists, often described their initial contact with these unmotivated patients as the result of other providers' referrals in dire health circumstances. The consequence of these types of perceptions is that providers often placed blame for lack of healthy change directly on the patient and potentially eschewing other information relevant to clinical work. Moreover, reported provider recommendations to patients incorporated the narrow view that health and wellness results only from individual actions.

Challenges

Healthcare providers and support providers reported a variety of challenges to their practices including feeling misunderstood or unappreciated by patients, issues with intra-provider and intra-agency communication. However, the most commonly reported challenge across all types of providers was the lack of time to engage in a more meaningful and thorough manner with patients. According to providers' accounts, lack of time has a significant impact

on their relationships and communication strategies. One provider explained that the lack of time not only presents limits on care, but also a provider's ability to emphasize the importance of making healthy changes to patients. These issues present serious implications for the quality of care that patients receive as relevant clinical information may be missed and there is a lack of opportunity to foster provider-patient relationships that are characterized by in-depth communication and trust.

Resilience and health

Among necessary changes to address barriers are the needs for providers to obtain information on how patients understand their messaging, how to more effectively connect with patients in short visits, and how to recognize patient bodies as entities inhabited by agents who have the ability and desire to make changes in their lives. In searching for the positive changes in behavior that patients may choose to make, and finding out what it is they do already know about health, providers can increase trust and the “leg work” they need to be advocates for closing vast inequities in health. It may also be the case that physicians themselves, who are suffering from displeasure with their jobs, may benefit from exploring their own resilience practices and knowledge to understand the ways that their patients may be unable to change, or successes in how they can change to obtain a healthier life. It is in this area of learning that anthropologists and healthcare scholars and providers may choose to work together to develop and provide collaboration and training for closing the gaps in between.

Acknowledgements

We thank all the community researchers and project partners who participated in the development of *Health Resilience*, and continue to collaborate on strategies for systems change and policy recommendations based on the findings of this research.

Funding Statement Research reported in this publication was supported by the National Institute On Minority Health And Health Disparities of the National Institutes of Health under Award Number P20MD006872 and the Kresge Foundation's Safety Net Enhancement Initiative (SNEI) The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health or the Kresge Foundation.

Biographies

Lisa J. Hardy, PhD is a medical anthropologist currently serving as Assistant Professor of anthropology at Northern Arizona University. Dr. Hardy's current research includes patient--provider communication and resilience, which she studies through her project within the Center for American Indian Research (CAIR) funded by the National Institutes of Health. Hardy's other work includes national healthcare studies, evaluation for community coalitions, health policy research and evaluation, and training for healthcare providers on social determinants of health. She is currently writing, working, and living research on the health impacts of social connectedness. lisa.hardy@nau.edu

Elizabeth Hulen, MA is a medical anthropologist and a recent MA graduate from Northern Arizona University where she has also worked as a research specialist and part-time faculty member. Ms. Hulen's research interests include primary health care delivery, U.S. health

care policy, qualitative research methods, and human development across the lifespan. She currently serves as a research staff member in the Research and Development Service at the Veterans Affairs Portland Health Care System where she is involved in health services research and learner evaluation projects. ehulen@nau.edu

References

Hardy, L.J.; Figueroa, A.; Hughes, A.; Hulen, E.; Corrales, C.; Scranton, R.; Cruz, C. CES4Health.info. 2014. Toolkit for Community-engaged Wellness Mapping.