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How Do You Build a "Culture of Health"? A Critical Analysis of Challenges and Opportunities from Medical Anthropology

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Abstract

The Robert Wood Johnson Foundation's Culture of Health Action Framework aims to ''make health a shared value'' and improve population health equity through widespread culture change. The authors draw upon their expertise as anthropologists to identify 3 challenges that they believe must be addressed in order to effectively achieve the health equity and population health improvement goals of the Culture of Health initiative: clarifying and demystifying the concept of ''culture,'' contextualizing ''community'' within networks of power and inequality, and confronting the crises of trust and solidarity in the contemporary United States. The authors suggest that those who seek to build a ''Culture of Health'' refine their understanding of how ''culture'' is experienced, advocate for policies and practices that break down unhealthy consolidations of power, and innovate solutions to building consensus in a divided nation.

Keywords: culture of health, anthropology, health equity

Introduction

In 2014, the Robert Wood Johnson Foundation (RWJF), the second-largest funder for health in the United States after the National Institutes of Health, proposed a new framework for improving population health and reducing health inequities in the United States. The core of RWJF's ''Culture of Health Action Framework'' is the goal of ''making health a shared value''[1] by achieving what some describe as a ''cultural shift'' in the United States.[2] To achieve this shift, as one prominent commentator observed, it will be necessary to ''map culture, a term commonly associated with anthropology, onto the specialized language of health policy, health care, and health services research.''[3] To date, however, anthropologists have had little input into how this might be achieved.

As medical anthropologists who work on population health and who have worked with RWJF in various capacities, the research team has followed the development of the Culture of Health with interest. Following is an anthropological view of what the team regards as the most promising aspects of the Culture of Health approach, and what it sees as concerning. This analysis is offered in the hope of advancing a sharper and more critically informed way for population health researchers and professionals who work with the Culture of Health Framework, or are simply committed to its goals, to tackle health inequities.

The research team is enthusiastic to see the hallmarks of their discipline reflected in the RWJF Framework, including an awareness of how history, context, and politics influence the opportunities available to individuals and communities. Notably, the Framework resists the allure of the quick fix in favor of confronting structural forces that lead to health inequities. Many new RWJF-funded initiatives, including those that seek to shape government policies, track hyper-incarceration rates, and build cross-sector collaborations, recognize the different levels at which inequalities are born and perpetuated and aim to confront their root causes (eg,

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County Health Rankings and Roadmaps, VCU Center on Society and Health, HOPE Initiative, American Communities Project, Interdisciplinary Research Leaders initiative). RWJF rightfully acknowledges that addressing these problems will require buy-in from stakeholders far beyond the health sector, and that good ideas can come from many corners – including from the same disadvantaged groups it seeks to aid.[4]

At the same time, the research team's anthropological training foregrounds 3 challenges that it believes will need to be addressed in order to achieve the population health equity goals of the Culture of Health. These challenges include (1) clarifying and demystifying the concept of culture, (2) grounding ''community'' interventions in larger networks of power and inequality, and (3) responding to the crises of solidarity and trust in the contemporary United States. These challenges, their implications, and possible solutions are described in the following sections.

Challenge #1: Clarify and Demystify "Culture"

What does the ''culture'' in ''Culture of Health'' mean? In a recent webinar, RWJF explained that, ''A Culture of Health exists when individuals, communities, and organizations prioritize and promote enhanced well-being for all and value health as fundamental to the nation's social and economic future.''[5] The idea is that in order to improve overall population health and health equity in the United States, a cultural shift is needed on a grand scale. The Culture of Health Action Framework is organized into 4 action areas: ''making health a shared value,'' ''fostering cross-sector collaboration to improve well-being,'' ''creating healthier, more equitable communities,'' and ''strengthening integration of health services and systems.''[6] As comprehensively as the Foundation has defined a ''Culture of Health,'' however, it has shied away from defining ''culture'' itself.

In describing the genesis of the Culture of Health, the Foundation has explained that, ''we decided that the real aspect of our daily lives that we needed to address was our culture and the ways in which our culture makes it more difficult, not less difficult, to make healthy choices; the ways in which our culture reinforces policies and practices that are not promoting health; and the ways in which our culture defines health very narrowly, rather than broadly, and not in terms of people's overall well-being.''[7] These are strong statements that cast a great deal of blame for the United States' health-related ills on something called ''our culture.'' But what is ''culture?'' Whose culture is ''ours?'' And why does it matter to health?

According to most contemporary sociocultural anthropologists, ''culture'' is not a static ''thing'' experienced in the same way by all members of clearly defined groups. Neither is it capable of the kind of agency that the aforementioned description implies.[8] Rather, ''culture'' captures the patterned ways in which individual lives unfold in multilayered, dynamic group contexts. Cultural groups are internally diverse, and group boundaries are continually negotiated in response to internal as well as external challenges. Culture is also intersectional: most people belong to multiple groups at once, and those groups are shaped by varying social, economic, political, and environmental contexts. As a result, different aspects of identity – including race, class, religion, gender identity, sexual orientation, nationality, and language – may intersect in different ways for different people in different contexts.[9] In sum, contemporary anthropologists think of ''culture'' as a way of describing the complicated relationships that exist between individuals and the many groups with which they identify and associate. As a result, anthropologists avoid assuming that individuals belong to a singular ''culture'' based on their association with a particular nation-state, demographic category, or ''population.''

RWJF's statement is thus troubling to the team because it seems to entail 2 assumptions that anthropological evidence does not support: that (1) most Americans adhere to a common set of beliefs, values and attitudes, and (2) these beliefs, values, and attitudes are key drivers of poor population health in the United States.

The first assumption exemplifies a ''deep values'' approach to culture that pays inadequate attention to cultural heterogeneity. The research team concurs with Schudson and Baykurt,[10] who argue that reducing culture to a set of consistent values neither reflects how culture actually works, nor offers an effective blueprint for developing a culturally informed approach to health reform. For example, one frequently cited model for how to improve health through cultural change is the campaign to reduce US smoking rates in the last decades of the twentieth century.[11] Smoking reduction in the United States was certainly a public health victory, but framing this story as a tale of nationwide cultural shift obscures both the important population differences that remain and the economic and social factors that contribute to those differences. Smoking reductions in the United States were concentrated among wealthier, whiter, and better educated populations – and notably, were accompanied by steep increases in smoking in many developing countries as corporations transferred marketing efforts elsewhere.[11] The result has been a shift in the burden of smoking-related disease and mortality from wealthier to poorer populations, both nationally and globally.[12] This example shows how insufficient care in using the term ''culture'' may lead researchers to overlook or misinterpret the effects of structural inequities.[13]

This risk of misinterpretation also drives the team's discomfort with the second assumption: that faulty ''culture'' is to blame for poor population health. The claim that ''our culture makes it more difficult, not less difficult, to make healthy choices'' provides a good example of what the team finds misleading about using ''culture'' to describe the roots of poor health. To be clear: The research team could not agree more with the general sentiment behind this statement. In anthropological work, the team has observed myriad ways in which people face profound constraints on the choices they make. Even people who want to choose lifestyles designated as ''healthy'' are often unable to choose healthy foods,[14] stop smoking,[11] work safely,[15] or recover from drug addiction.[16] In practice, RWJF, its partners, and population health practitioners following its lead are addressing many of these issues in nuanced ways.

At the same time, language matters. By characterizing constraining forces as problems of ''culture,'' this approach invites confusion between the role of *cultural experience*, and *structural forces* such as corporate marketing, political interests, and racial discrimination.

The contrast between responses to substance abuse in the late twentieth century and more recent approaches to this problem provides an instructive example of why the terms used matter. According to media and policy makers at the time, the heroin and crack ''epidemics'' of the 1970s and 1980s were caused by a ''culture of poverty'' in low-income black and Latino neighborhoods and the supposed moral failings of neighborhood residents.[17] These claims were mobilized to support a misguided ''War on Drugs'' and associated exponential rise in incarceration rates of black and Latino Americans that persists to this day.[18]

The current ''opioid crisis,'' in contrast, has been portrayed as a problem of unscrupulous pharmaceutical marketing and careless overprescribing, of which innocent white Americans are the primary victims. Responses include decriminalization policies such as harm reduction and diversion from sentencing to treatment. Although these measures are laudable, Hansen and Netherland[16] have demonstrated that these discrepant policy responses exacerbate racial-ethnic inequalities in the social, economic, and health consequences of drug use. Vague or ill-defined references to ''culture'' can deflect attention from the unequal and discriminatory contexts in which health crises emerge, while delaying the development of effective disease control responses for all.

How might an anthropological approach help us understand the role that ''culture'' *does* play in addiction? Anthropologists who study drug use have delved into the lived experiences of drug users, their families, and those who care for them.[19–21] They have spoken with and observed individuals experiencing addiction – and the groups with which they associate – often over a period of years. Anthropologists also have researched the political, historical, and economic contexts in which drug users live. By triangulating among these data, anthropological studies have sharpened our understanding of how and why drug users begin and continue to use drugs, as well as how they experience their addiction, navigate relationships, and pursue recovery. The resulting insights have helped health professionals and policy makers assess where and why to invest resources in ways that are more likely to produce desired results.[22] The core idea is simple: by understanding what people are experiencing in everyday life, we dramatically strengthen our ability to help.

The qualitative methods anthropologists use to cultivate this understanding are collectively known as *ethnography*. Ethnography includes participant observation, in-depth interviews, and other strategies for deep, usually long-term engagement with populations of interest. Ethnographic methods can clarify how individuals function simultaneously as members of multiple populations; how those populations interact; and the impact of those interactions on individuals' lives. Ethnographers are adept at elucidating the gaps between what people say they do and what they actually do – and the reasons for such differences. In short, ethnography reveals people's cultural realities as they are actually lived. Understanding cultural realities – in all of their complexity and within their social, political, and economic context – is crucial to achieving health equity.

Challenge #2: Ground "Community" Intervention in Larger Structural Change

A related concept also requires greater clarity: ''community.'' In population health, this term has multiple meanings. Often ''community'' refers to a group of people in a specific neighborhood or other geographically bounded area. At other times it refers to a self-selected group with shared interests, including groups that may be geographically dispersed, such as the ''medical community'' or online ''communities.''

Another usage – working ''in communities'' (or ''in community'') – tends to carry a more specific connotation: poor people, or people of color, in a defined geographical area. This use of ''community'' raises concerns. It introduces an implicit divide between the interests, goals, and capacities of those lacking in power – ''community members'' – and those with access to power, including care providers and researchers. In this usage, ''communities'' often are cast as a locus of ''culture'' that is defective and needs improvement.[23] When using ''community'' in this way, certain unspoken assumptions tend to be made. Neighborhoods inhabited by poor people and people of color are defined as the ''problem,'' and then become natural sites for intervention. Attention is too easily directed away from the roles played by the harmful policies, systems, and individuals in power who helped to create those problems in the first place.

Overwhelming evidence shows – and those working in ''community health'' know – that macro-level social structures extending far beyond the bounds of particular communities are primary drivers of health inequities.[24] When working with local populations, one must remember that city, state, national, international, and corporate policies can place profound constraints on collective opportunities to be healthy. The same ''communities'' that a Culture of Health is meant to lift up then often pay the highest price for policies beyond their control that pollute the environment, dismantle social safety nets, defund education, and market unhealthy products.[25] Given these realities, many ''risky'' behaviors, such as smoking or overeating, can be better understood as markers of collective risk (ie, as forms of risk that are themselves structurally determined).[13,26]

Even when the harmful impact of macro-level policies is acknowledged, proposed interventions still too often focus on the behaviors of community members themselves. But a community cannot effectively improve the health of its members if neighboring locales, local and national governments, and transnational corporations refuse to acknowledge their own roles in creating population health problems, or in potentially enacting comprehensive solutions.[24,27] As anthropologists, the research team knows that unless both environments of risk and the agents and policies responsible for perpetuating those environments are confronted, lasting change will be impossible.[27–29]

Many researchers and practitioners who are working with RWJF's Culture of Health Framework are raising awareness about how structural factors constrain choices, increase population-level risk, and impede change at the community level. And they are thinking deeply about how macro-level social structures endanger the health of communities and perpetuate community-wide poor health.[30] Although some initiatives have taken the important step of ensuring that those affected by structural inequalities help set agendas or even establish the terms of debate (see, eg, Visualizing Health Equity), the team remains concerned that such engagement efforts may only reach those already involved

with established institutions and organizations, or with leaders of recognized, established ''communities.'' This could leave those individuals on the furthest margins, including homeless or undocumented individuals, on the sidelines – thereby unintentionally deepening inequities.[19] These approaches also may circumscribe the boundaries of individuals' associations unnecessarily, by sorting them into discrete ''communities'' rather than acknowledging their more complex lived realities.

Ethnographic methods can help to assess how people understand their roles within constraining social structures – and what ''community'' really does or does not mean to them. These methods make it possible to track how the hardships of everyday life for those who are underserved or forgotten become ''embodied'' in ways that impair physical, emotional, and existential well-being.[15,31] By spending intensive periods of time engaging people as they move through the wide-ranging and overlapping places, groups, and social structures with which they interact, one can understand the intersections of structure and experience in ways that a reliance on traditional understandings of ''community'' cannot do.

Because people's experiences are *not* entirely bounded by ''communities,'' developing programs to address health problems and behavior at the ''community'' level, will always be insufficient – no matter how well designed an intervention may be. To effectively achieve the goals of a Culture of Health, we must work actively to create a more just and equitable society writ large. Vulnerable populations must be shown convincingly that their lives matter.[32] Structural racism and social inequality must be counteracted in policy and practice.[13] These are not impossible tasks – as historical successes such as the desegregation of schools and hospitals, the introduction of Medicare and Medicaid, and the implementation of labor laws make clear. They are, however, tasks that must continually be pursued and renewed. Otherwise, any improvement in the health of a particular ''community'' will be a fragile victory at best.

Challenge #3: Build Consensus in a Divided Nation

For many population health professionals and researchers, statements that have accompanied RWJF's Culture of Health campaign such as ''health is interdependent''[33] and ''we are all in this together,''[34] are self-evident truths. However, current US political dynamics clearly demonstrate that not all Americans agree that, ''we are all in this together.'' Solidarity, by many standards, appears to have reached a new low.

RWJF-funded research has begun to identify some profound obstacles to building the type of solidarity that a sea change in population health equity would require. For instance, Gollust, Lantz, and Ubel found strong associations between political party affiliation and willingness to accept public health explanations regarding social determinants of health.[30,35] Findings from the American Health Values Survey revealed disagreement as to whether health equity should be a national goal.[36] And the ongoing ARCHES study is shedding light on why some Americans – advantaged and disadvantaged alike – are unable or unwilling to recognize the impact of structural factors on health, or the interconnections between their own health and the health of people they perceive as different from themselves.

Fueling this reluctance to value health equity or recognize the importance of social determinants of health is the crisis of trust in ''facts.'' Public trust in government and the news media is decreasing in the wake of ''fake news'' and ''alternative truth'' claims.[37,38] Targeted information flows create echo chambers that reinforce existing prejudices and diminish any sense of interconnectedness Americans once may have felt.[38] A growing mistrust in science – fueled by filter bubbles and selective ''information curation'' online – is undermining confidence in public health and medical expertise, diminishing the persuasive power of data and fueling ''medical populism'' that blames experts and outsiders for public health threats.[39] In this era, data of any variety – including ethnographic data – may be unlikely to convince people of something they do not already believe. One clear recent example of this with major population health consequences is the vaccine refusal movement. This movement, fueled by online echo chambers, has questioned the science of vaccination and the ability of scientists to assess the impact of vaccinations over time, and has raised suspicions regarding the profit motives of the pharmaceutical industry in driving vaccine-related policy.

How can scholars, practitioners, and policy makers advance the goals of a Culture of Health when some see both the legitimacy of scientific evidence and the value of health equity as up for debate? As a first step, the research team suggests acknowledging that these debates exist – and that they need to be confronted rather than avoided. Anthropological training has taught the team that what counts as ''facts'' or ''truth'' has always been subject to social and cultural construction and interpretation.[40] Moreover, decisions about whose health deserves collective investment (and whose does not) are often informed less by evidence than by the moral commitments and biases of policy makers, clinicians, and voters.[41] In short, it is not enough to introduce facts and evidence regarding the impact of social and structural determinants, the collective benefits of promoting health equity, or even the benefits of vaccination. People need tools and skills for interpreting evidence, and they must be convinced of its value in the context of their own lives.

To meet this challenge, innovative solutions are needed. First, public health needs better public relations. Funders could support public health leaders, scholars, and educators in developing innovative ways to more effectively communicate to the public the vital role of a healthy population for the security and stability of *everyone's* lives. Second, our team members know from their own classrooms that students struggle to identify what is and is not a legitimate source of information in today's unruly marketplace of ideas. Population health initiatives should confront this problem by supporting school-based interventions that strengthen scientific understanding, cultivate scientific sophistication, and help students navigate and critically assess diverse information sources. Third, there now are excellent tools and frameworks to help clinicians and health care institutions understand and responsibly address social and structural determinants of health.[42] They can, and should be, part of how clinical providers are trained and health care institutions are evaluated. Finally, supporting collaborative initiatives that work across racial and political lines to improve health and social life could help heal our national divides. For example, the emergence of a powerful youth-led

anti-gun violence movement is uniting people from all walks of life – including suburban parents, inner city residents, Black Lives Matter activists, and elementary and high school students – to participate in nonpartisan advocacy for increasing voter registration, passing gun control laws, and preventing gun violence. In short, it is possible to take meaningful strides toward reaffirming the value of science, building consensus and respect, and promoting solidarity in a divided nation. First, however, it is imperative to recognize that declaring that we are ''all in it together'' is not a neutral stance but a value statement grounded in a particular cultural vision that must be promoted and defended.

Conclusion

With its Culture of Health Action Framework, RWJF has taken on the formidable task of innovating answers to one of the biggest questions in population health: How do we move away from confronting health disparities by tackling one disease at a time, and instead transform an entire system? RWJF's willingness to tackle this problem is inspiring, hopeful, and in line with goals anthropologists share. It is work that is both vital and urgent, not only because of the high stakes of these issues, but also because of the vast reach and importance of RWJF as the second-largest grant funder of health programs in the United States. However, the challenges identified here will need to be addressed in order for leaders and stakeholders who are committed to improving health equity and achieving a ''Culture of Health'' to maximize their positive impact and minimize potential negative consequences.

To address these challenges, the research team suggests that those seeking to build a Culture of Health take 3 key steps: First, avoid equating ''culture'' with simplistic categories based in geography, ethnicity, or assumptions, and instead consider how cultural realities, in all their complexity, are lived and experienced. Second, advocate for federal and local policies that break down unhealthy consolidations of power and money and expand social safety nets, recognizing that neither individuals nor the many communities with which they associate can be healthy if American society is unhealthy and unequal. Third, develop innovative approaches to building consensus about the importance of health equity and population health in a divided nation. On a national level, a Culture of Health that embraces these critical interventions would have the greatest likelihood of impact on the lives of the greatest number of people. As medical anthropologists, it is a vision we would be enthusiastic to support.

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