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Cultural Health Capital on the margins: Cultural resources for navigating healthcare in communities with limited access

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Communities struggling with access to healthcare in the U.S. are often considered to be disadvantaged and lacking in resources. Yet, these communities develop and nurture valuable strategies for healthcare access that are underrecognized by health scholars. Combining medical sociology and critical race theory perspectives on cultural capital, this paper examines the health-relevant cultural resources, or Cultural Health Capital, in South Texas Mexican American border communities. Ethnographic data collected during 2011–2013 in Cameron and Hidalgo counties on the U.S.–Mexico border provide empirical evidence for expanding existing notions of health-relevant cultural capital. These Mexican American communities use a range of cultural resources to manage healthcare exclusion and negotiate care in alternative healthcare spaces like community clinics, flea markets and Mexican pharmacies. Navigational, social, familial, and linguistic skills and knowledge are used to access doctors and prescription drugs in these spaces despite social barriers to mainstream healthcare (e.g. cost, English language skills, etc.). Cultural capital used in marginalized communities to navigate limited healthcare options may not always fully counteract healthcare exclusion. Nevertheless, recognizing the cultural resources used in Mexican American communities to facilitate healthcare challenges deficit views and yields important findings for policymakers, healthcare providers, and advocates seeking to capitalize on community resources to improve healthcare access.

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1. Introduction

> “I got some [arthritis] medicine for my mom in Matamoros [Mexico]. I crossed [the border from Mexico] with my girlfriend in her truck and we put the medicine under my seat, tucked it under … You just make sure [the Customs and Border Patrol officers] can't see it. It's not a big deal. You just hide it.” – Jeanette, 23 years old

Smuggling prescription drugs over the border from Mexico is one example of the many healthcare access strategies developed by Mexican American Texas border communities. In a region with high uninsurance rates, low income, large populations of immigrants and U.S. citizens who do not qualify for healthcare safety net programs, and close geographic proximity to Mexico, healthcare frequently operates “on the margins,” or in healthcare spaces outside of mainstream U.S. public and private healthcare institutions. There is no public hospital in South Texas and the towering private hospitals in the cities of Harlingen, Brownsville, and McAllen are often not the primary sites of healthcare access for Mexican Americans living on the U.S.–Mexico border. Healthcare is frequently found in physical and social spaces that are on the edge or wholly outside of the healthcare resources and experiences of the insured middle class U.S. population. These spaces may be community health clinics, Mexican doctor's offices and *farmacias*, flea markets, and the homes of friends and family. It remains unclear how patients negotiate healthcare on the margins. I examine here what cultural resources South Texas Mexican American communities mobilize to navigate limited healthcare options and consider what these resources reveal about the nature of health-relevant cultural capital in U.S. communities of color.

There are several factors fueling the exclusion of Latinas/os from access to mainstream U.S. healthcare and prompt use of particular cultural resources that help with healthcare exclusion. These forces persist to varying degrees even since the implementation of the 2010 Affordable Care Act, but are still very relevant in states like Texas that did not expand Medicaid: 1) Social services eligibility

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policies (Park, 2011; Yoo, 2008; Derose et al., 2007); 2) Immigration policies and enforcement (Beniflah et al., 2013; Madden, 2013; Portes et al., 2012; Brabeck and Xu, 2010; Berk et al., 2000); 3) Border security policies (Madden, 2013); 4) Low socioeconomic status (Derose et al., 2007; Phillips et al., 2000); and 5) Cultural and linguistic barriers (Portes et al., 2012).

A subset of healthcare access, access to prescription drugs, is considered in this paper because prescription drug access is vital to basic health maintenance, especially for chronic conditions. In addition, while U.S. government and pharmaceutical industry aid programs offer some help to low-income patients, many ineligible immigrants and un- and underinsured individuals still struggle with accessing prescription medication (Cunningham, 2002). Mexican Americans in particular are more likely than non-Hispanic whites to face prescription drug access barriers due to linguistic and economic issues, lack of access to insurance and social programs, and immigration policies (Chen et al., 2010). Uninsured patients like Jeanette (quoted above), as well as insured patients seek the cost advantages of Mexican medications in order to deal with prescription access problems (Calvillo and Lal, 2003). Cross-border healthcare is one of many healthcare access strategies that use health-relevant Mexican American cultural knowledge and skills. This and several other strategies will be used to conceptualize how socially, politically, and economically marginalized communities activate cultural capital to manage barriers to healthcare.

2. Theoretical frameworks: using cultural capital to manage healthcare exclusion

The healthcare knowledge and strategies used by marginalized social groups bridges literature on cultural capital in medical sociology and critical race theory. I argue that the cultural capital used in Mexican American border communities to navigate exclusion from U.S. healthcare represents health knowledge that expands dominant notions of health-relevant cultural capital. Drawing on critical race theory, I conceptualize what cultural resources, skills, and knowledge marginalized communities use to navigate structural oppression in healthcare.

Cultural capital describes the skills and knowledge that are considered legitimate and useful in dominant society (Bourdieu, 1986). Health research has most frequently focused on economic and social capital, but Shim (2010) adapts the concept of cultural capital, and Bourdieu's insight into how cultural practices produce and maintain social stratification, for the healthcare field. Certain kinds of cultural capital, which Shim labels Cultural Health Capital (CHC), may be used in the field of healthcare, and specifically in interactions between doctors and patients, to accrue benefits. The assets comprising CHC may change over time and across social contexts. Given the current U.S. healthcare system emphasis on consumerism, proactive patients, and self-surveillance, certain characteristics accrue more healthcare benefits than others (Shim, 2010). Modern forms of CHC include (but are not limited to): 1) knowledge of medical vocabulary; 2) efficient communication skills; 3) belief in self-discipline; and 4) ability to prioritize the future and control future outcomes. CHC moves beyond notions of health literacy and self-efficacy by recognizing how such skills and resources offer direct, indirect, symbolic, and instrumental resources in healthcare interactions.

Not all patients have the forms of cultural capital that optimize "typical" doctor–patient interactions, i.e. a clinical encounter between a patient and a provider in a hospital or private practice. This may occur for two reasons: First, the ability to accrue and mobilize CHC is mediated by social position. Research on race and cultural capital shows how race, class, and other markers of social status may be reflected in CHC in ways that fuel disparities in quality of care (Wall, 1995; Malat, 2006; Shim, 2010). Shim (2010) explains that the high value of CHC in typical healthcare encounters produces inequalities because those without these resources often are not able to optimize their healthcare interactions. A "mismatch" occurs between the CHC expectations of providers and the cultural resources possessed by patients from marginalized social positions.

What is unclear from this picture is how cultural resources operate among people who are socially disadvantaged to the point that they are largely excluded from accessing these dominant healthcare spaces. What place do they have in cultural capital research? It follows that a second reason for why patients may not be able to use CHC in typical doctor–patient interactions is because some patients rarely, if ever, experience healthcare in these types of healthcare settings. The healthcare field is often imagined as these "typical" clinical spaces like hospitals and U.S. pharmacies. Low-income un- and underinsured Mexican Americans often lack inroads to these spaces and instead use flea markets, Mexican clinics, and other healthcare spaces not typically used by insured middle class people in the U.S. This means that the healthcare field for low-income Mexican Americans is a different terrain requiring additional types of health-relevant cultural capital not explicitly accounted for by the current concept of Cultural Health Capital. A deeper understanding of this health-relevant cultural capital is needed. Understandings of cultural resources used in marginalized groups and spaces are where I turn next.

Shim's discussion of how CHC can map onto hierarchies of class and race parallels critical race theory critiques of subtle, yet pervasive forms of racism whereby institutions devalue cultural capital developed in communities of color, and revere middle and upper class white cultural capital. Through the critical race theory lens that puts race and racial oppression at the forefront of social research, scholars identify kinds of cultural capital that exist in communities of color and criticize assumptions that people of color are at a cultural "deficit" compared to whites (Yosso et al., 2009; Yosso, 2005; González, 2002; González et al., 1995; Moll et al., 1992). The critical race theory critique of cultural capital provides groundwork for extending Shim's concept of Cultural Health Capital into communities of color without the normative assumption that they hold little or less valuable kinds of health-relevant cultural capital.

Critical race theory draws attention to ways race and racism affect social structures, which in this case is mainstream healthcare (Delgado and Stefancic, 2012; Yosso, 2005). Structures that (intentionally or unintentionally) support the "deficit view," which uses middle class white forms of cultural capital as the standard by which to judge communities of color are examples of how structures can maintain racial bias. Deficit views blame people of color for cultural capital "mismatches" between communities of color and institutions by assuming people of color lack cultural skills (according to white standards) (Yosso, 2005; García and Guerra, 2004). If the skills and values described by the Cultural Health Capital concept comprise white middle/upper middle class standards within healthcare, it could be easy to fall into reinforcing deficit views when examining healthcare marginalization in Mexican American communities. To avoid this pitfall, I adopt a critical race theory orientation that instead argues against deficit views by identifying cultural resources used to resist structural oppression.

Yosso (2005) and Yosso et al. (2009) explain how cultural capital developed in communities of color indeed has high exchange value (Yosso, 2005; Yosso et al., 2009). Yosso (2005) labels cultural resources "Community Cultural Wealth." This concept is intended to account for the cultural resources of students of color in the education field, but also offers important insights for healthcare. Community Cultural Wealth provides an opportunity to expand

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