Chapter 4

Barriers to and Facilitators of Older Adult’s Adherence to Health Recommendations: Towards an Engaging Two-way Health Communication

Rui Gaspar
William James Center for Research, ISPA- Instituto Universitário, Portugal

Samuel Domingos
William James Center for Research, ISPA- Instituto Universitário, Portugal

António M. Diniz
Universidade de Évora, Portugal

Roberto Falanga
Instituto de Ciências Sociais, Universidade de Lisboa, Portugal

ABSTRACT

Non-adherence to health recommendations (e.g. medical prescriptions) presents potential costs for healthcare, which could be prevented or mitigated. This is often attributed to a person’s rational choice, to not adhere. However, this may also be determined by individual and contextual factors implied in the recommendations communication process. In accordance, this chapter focuses specifically on barriers to and facilitators of adherence to recommendations and engagement with the healthcare process, particularly concerning the communication between health professionals and patients. For this, the authors present examples of engagement increment through different degrees of participation, from a one-way/directive towards a two-way/engaging communication process. This focuses specifically on a vulnerable population group with increasing healthcare needs: older adults. Future possibilities for two-way engaging communications are discussed, aimed at promoting increased adherence to health recommendations and people’s self-regulation of their own health.

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INTRODUCTION

“Patients are adherent when they do what their health professionals recommend” (DiMatteo, 2004; p. 200). When patients do not do what health professionals recommend, i.e. they are non-adherent, this may increment healthcare costs, by wasting human and material resources. In accordance, lack of engagement with the healthcare process in general and specifically lack of adherence to recommendations as communicated by health professionals, has been an important setback for health promotion effectiveness, in various healthcare systems across the world (see DiMatteo, 2004). To provide a contribution in this regard, this chapter aims to provide an overview of barriers to recommendations adherence and facilitators of people’s increased participation and engagement with their own health care process.

This chapter specifically focuses on the older adult’s population. There are some reasons that justify this focus. Over the past decades we have witnessed an increase in life expectancy, resulting in a greater prevalence of chronic diseases, with negative impact on the health systems (Bauer, Briss, Goodman, & Bowman, 2014; Sabate, 2003). It is estimated that most of the elderly have two or more diseases (van den Akker, Buntinx, Metsemakers, Roos, & Knottnerus, 1998; Ward & Schiller, 2013), and comorbidity often implies polypharmacy and subsequent undesirable drug-drug, drug-body, and/or drug-disease interactions (Arnold, 2008). This is frequently implemented through complex administration regimens that require daily habit changes implying effortful actions and strong adherence to what the health professionals recommend (Hajjar, Cafiero, & Hanlon, 2007). In agreement, a recent qualitative review focusing on randomized controlled trials interventions for chronic diseases, found that current methods of improving medication adherence are mostly complex and not very effective (Nieuwlaat et al., 2014; see also Haynes, Ackloo, Sahota, McDonald, & Yao, 2008). This is worrisome due to the fact that has been shown that the elderly have more difficulty in following recommendations than younger people, given that they ask for less clarification and tend to be less active regarding care for their own health, being therefore more susceptible to physical, psychological and social consequences from non-adherence (Branin, 2001). This has negative consequences as non-adherence to long-term therapy in chronic diseases achieves an average of 50% in developed countries (less in developing countries), increasing health costs and decrementing positive health outcomes. To tackle this, patient-tailored interventions should include not only the assessment of patient-related non-adherence factors but also contextual factors, namely those linked to the health professionals (Sabate, 2003) and the health recommendations communication process.

However, the consideration of these contextual factors is not the focus of many patient-tailored interventions, which potentially reduces their effectiveness. In fact, the reasons for non-adherence are often attributed to a rational choice from the individual and due to their individual characteristics and not as much to their surrounding context. This is in agreement with research that found a set of individual characteristics that may explain non-adherence (DiMatteo, 2004). However, equally important are factors related to the communication process itself and how engaged the actors of this process (e.g. patient, doctor) are in it. When these are considered, they focus mainly on the relationship between the patient and the health professional and/or on the communication content (e.g. how information is framed). However, this tells us little about how motivated the person is to engage with the process and adhere to what is recommended. 

It should be noted that upon communication of health information it is expected that people initiate a process of deliberation - a thoughtful, careful and lengthy consideration of the information (Davies, 2009) - and then implement the necessary actions to adhere to recommendations. However, providing information alone without people feeling engaged with the communication process and expecting the