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References

1. Ratzan SC. Editor's introduction: communication—the key to a healthier tomorrow. *Am Behav Scientist.* 1994;38: 202–207.

2. *Healthy People 2010.* 2nd ed. Washington, DC: US Dept of Health and Human Services; 2000.

3. Institute of Medicine. *Speaking of Health: Assessing Health Communication Strategies for Diverse Populations.* Washington, DC: National Academy Press; 2002.

4. Institute of Medicine. *The Future of the Public's Health in the 21st Century.* Washington, DC: National Academy Press; 2003.

5. Institute of Medicine. *Who Will Keep the Public Healthy?* Washington, DC: National Academy Press; 2003.

6. *State of the CDC Fiscal Year 2003.* Atlanta, Ga: Centers for Disease Control and Prevention; 2004.

7. Institute of Medicine. *America's Vital Interest in Global Health.* Washington, DC: National Academy Press; 1997.

8. Hornik RC. *Public Health Communication: Evidence for Behavior Change.* Mahwah, NJ: Lawrence Erlbaum; 2002.

9. Guttman N. *Public Health Communication Interventions: Values and Ethical Dilemmas.* Thousand Oaks, Calif: Sage Publications; 2000.

10. Des Jarlais DC, Lyles C, Crepaz N, TREND Group. Improving the reporting quality of nonrandomized evaluations of behavioral and public health interventions: the TREND statement. *Am J Public Health.* 2004;94:361–366.

The Contributions of Health Communication to Eliminating Health Disparities

The pressing need to eliminate health disparities calls on public health professionals to use every effective tool possible. Health communication, defined as the study and use of methods to inform and influence individual and community decisions that enhance health, was first recognized as a subset of the field of communication in 1975, when the Health Communication Division of the International Communication Association was founded.[1,2] The National Communication Association formed a division of the same name in 1985. In 1997, the Public Health Education and Health Promotion section within the American Public Health Association formally recognized health communication as part of its group. The peer-reviewed journal *Health Communication* began in 1989, followed 7 years later by the *Journal of Health Communication.* Today, while many communication departments and schools of public health offer limited graduate course work in health communication, there are fewer than a dozen comprehensive programs in health communication.

The federal government has recognized the contributions of health communication. The Centers for Disease Control and Prevention developed an office of communication in 1996 with the purpose of diffusing the science of health communication throughout the agency. The National Cancer Institute, in 1999, developed an "Extraordinary Opportunity in Cancer Communications," which included awarding Centers of Excellence in Cancer Communication to 4 universities; 2 of the 4 centers explicitly focus on research in health communication aimed at health disparities. In addition, for the first time, health communication is part of the Healthy People 2010 objectives.[3]

THE SCOPE AND LIMITATIONS OF HEALTH COMMUNICATION

These achievements not withstanding, the public health community seems to have a limited understanding of what health communication can offer to the elimination of health disparities. According to the National Cancer Institute, health communication can increase the intended audience's knowledge and awareness of a health issue, problem, or solution; influence perceptions, beliefs, and attitudes that may change social norms; prompt action; demonstrate or illustrate healthy skills; reinforce knowledge, attitudes, or behavior; show the benefit of behavior change; advocate a position on a health issue or policy; increase demand or support for health services; refute myths and misconceptions; and strengthen organizational relationships.[4(p3)]

However, health communication alone, without environmental supports, is not effective at sustaining behavior changes at the individual level. It may not be effective in communicating very complex messages, and it cannot compensate for lack of access to health care or healthy environments.[4(p3)] Nonetheless, we believe that public health professionals should use the full range of health communication strategies in the effort to eliminate health disparities.

THE RANGE OF HEALTH COMMUNICATION STRATEGIES

Many are familiar with mass media campaigns aimed at stimulating individual behavior change. However, there is less familiarity with other forms of health communication that can be effective in the context of health disparities. Health communicators can bring their expertise to bear in entertainment-education, media advocacy, new technology, and interpersonal communication, including patient–provider communication.

Entertainment-Education

Entertainment programming in the media is a powerful way

to communicate health information, especially for minority audiences, who are heavy consumers of this type of media. Several research studies have demonstrated that even brief exposure to health information and behaviors through entertainment media can have strong effects. In surveys (n=3719) conducted by Porter Novelli during 2001, more than half of regular prime time and daytime drama viewers reported that they learned something about a disease or how to prevent it from a TV show. Among minority viewers who watch regularly, 70% of Hispanic women, 65% of Black women, and 64% of Black men said they took some action after hearing about a health issue or disease on a TV show.[4] More than 50% of Black men and women reported that a storyline helped them to provide information to friends or family, as did 60% of Hispanic women.[4] Entertainment programming has the capacity to reach significant proportions of the populations experiencing health disparities.

Media Advocacy

Media advocacy is defined as the strategic use of mass media and their tools, in combination with community organizing, for the purpose of advancing healthy public policies.[5(p338)] Because the roots of health disparities extend to social, economic, and political conditions, media advocacy, which moves beyond the focus on the individual, holds promise as one form of health communication to address health disparities. One example of such a campaign is the Uptown Coalition in Philadelphia, which used the media and community organizing to defeat RJ Reynolds's proposed campaign to market Uptown cigarettes in African American communities.

Interactive Health Communication

Interactive technology, "computer-based media that enable users to access information and services of interest, control how the information is presented, and respond to information and messages in the mediated environment,"[6(p2)] has created new opportunities for health communication that can overcome barriers such as low literacy and expand opportunities to tailor and personalize information. One of the pioneer applications of such technology is the Comprehensive Health Enhancement Support System (CHESS), for which there is impressive research evidence of its potential for reducing disparities. In a study of the use of an HIV CHESS application, women and minorities made more use of several information tools than men and nonminorities, and minorities and those with less education used the decision and analysis tools more than nonminorities and people with more education, even though these tools were the most complex in the system.[7] Similar results were found in a pilot study of low-income, African American women with breast cancer.[7] Yet computer access issues prevent these approaches from achieving their potential in reducing health disparities.

Interpersonal Communication

Interpersonal communication theory helps us understand the provider–client interaction, the role of social support in health, and the ways in which interpersonal relationships influence health behaviors and decision-making. Clearly, the relationship between patient and provider can exacerbate health disparities. Van Ryn and Fu[8] suggest that providers may contribute to health disparities by influencing clients' views of themselves and their relation to the world, by differentially encouraging health promotion and disease prevention behaviors and services, and by withholding access to treatments or services and denying benefits and rights. They cite evidence of physicians' contributions to racial/ethnic disparities in kidney transplant rates and cardiac procedures, in pain assessment and control, and in mental health services. They argue for interventions to help providers avoid their own biases as one way to reduce disparities. Ashton and colleagues[9] examined communication between providers and minority patients and found that poor communication is linked to health disparities and requires specific interventions to address communication patterns.

Social support is another communication behavior that has profound consequences for mental and physical well-being.[10] Yet there is evidence that kinship support networks are deteriorating in low-income and minority communities because of unemployment, transience, and substance abuse.[11] Virtual support networks are becoming increasingly important, but again, access is an issue in underserved communities. Much more needs to be learned about the impact of culture on both expectations of support and the effects of support.

Cline's[12] argument for shifting the focus of interpersonal communication about health from formal to informal contexts such as everyday talk highlights a rich and untapped dimension of communication that could contribute to reducing disparities. Certainly, the impact of interpersonal communication through the use of lay health advisors, respected in their communities, is well documented. Extensive research on tailoring and targeting health messages promises new opportunities for reaching those who suffer most from health disparities.

CULTURAL DIFFERENCES AND HEALTH COMMUNICATION

However, in all these efforts, health communicators often struggle to understand the audiences they seek to reach, frequently equating culture in a simplistic fashion with race and ethnicity. The Institute of Medicine[13] argues that culture has been poorly examined in the context of health communication, asserting that to consider culture requires significant exploration beyond the typical variables of race, ethnicity, and socioeconomic status. According to the Institute, health communication campaigns typically address the issue of diverse audiences in 1 of 3 ways: by developing a communication campaign with common-denominator messages relevant to most audiences; by developing a unified campaign with systematic variations in messages to increase relevance for different audience segments, retaining one fundamental message; or by developing distinctly different messages or interventions for each audience segment.[13]

Many health communication interventions address what Resnicow and Braithwaite[14] refer to as the surface structure of a culture. Addressing surface structure includes matching

messages and channels to observable social and behavioral characteristics of a culture, for example, familiar people, foods, music, language, and places. It may be more important to address deep structure, which reflects the cultural, social, psychological, environmental, and historical factors that affect health for a minority community. Resnicow and Braithwaite argue that when health communication appropriately addresses surface structure, it increases receptivity to and acceptance of the campaign, but when it also addresses deep structure, it conveys true salience to the community it seeks to reach. Clearly, there is much to learn about creating health communication interventions that appreciate the complexity of culture, and then evaluating the impact of such programs on eliminating health disparities.

Eliminating health disparities requires that public health professionals expand their use of health communication strategies in comprehensive interventions aimed at effecting individual, community, organizational, and policy change. Such interventions can effectively address the multiple determinants of health that underlie disparities. However, to design effective interventions, we must understand the complexity of culture and integrate cultural factors into our health communication efforts. Furthermore, we must work collaboratively with communities experiencing disparities to overcome the historical context of distrust and create meaningful, effective health communication interventions. ■

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References

1. *Making Health Communication Programs Work.* Bethesda, Md: National Cancer Institute; 2001.

2. Freimuth V, Cole G, Kirby S. Issues in evaluating mass media health communication campaigns. In: Rootman I, Goodstadt M, Brian Hyndman, et al., eds. *Evaluation in Health Promotion: Principles and Perspectives.* Copenhagen, Denmark: WHO Regional Office for Europe; 2001:475–492.

3. *Healthy People 2010: Understanding and Improving Health.* Washington, DC: US Dept of Health and Human Services, Office of Disease Prevention and Health Promotion; 2000.

4. Office of Communication, Centers for Disease Control and Prevention. Entertainment Education: Overview. Available at http://www.cdc.gov/communication/surveys/surv2001.htm. Accessed July 21, 2004.

5. Institute of Medicine. *The Future of the Public's Health in the 21st Century.* Washington, DC: National Academies Press, 2003.

6. Street RL Jr, Rimal RN. Health promotion and interactive technology: A conceptual foundation. In: Street RL Jr, Gold WR, Manning T, eds. *Health Promotion and Interactive Technology.* Mahwah, NJ: Lawrence Erlbaum Associates Inc; 1997:1–18.

7. Hawkins RP, Pingree S, Gustafson DH, et al. Aiding those facing health crises: the experience of the CHESS project. In: Street RL Jr, Gold WR, Manning T, eds. *Health Promotion and Interactive Technology.* Mahwah, NJ: Lawrence Erlbaum Associates Inc; 1997:79–102.

8. Van Ryn M, Fu S. Paved with good intentions: do public health and human service providers contribute to racial/ethnic disparities in health? *Am J Public Health.* 2003;93:248–255.

9. Ashton C, Haidet P, Paterniti D, et al. Racial and ethnic disparities in the use of health services: bias, preferences or poor communication? *J Gen Intern Med.* 2003;18:146–152.

10. Albrecht T, Goldsmith D. Social support, social networks, and health. In: Thompson T, Dorsey A, Miller K, Parrott R, eds. *Handbook of Health Communication.* Mahwah, NJ: Lawrence Erlbaum Associates Inc; 2003: 263–284.

11. Roschelle A. *No More Kin: Exploring Race, Class, and Gender in Family Networks.* Thousand Oaks, Calif: Sage Publications; 1997.

12. Cline R. Everyday interpersonal communication and health. In: Thompson T, Dorsey A, Miller K, Parrott R, eds. *Handbook of Health Communication.* Mahwah, NJ: Lawrence Erlbaum Associates Inc; 2003:285–318.

13. Institute of Medicine. *Speaking of Health: Assessing Health Communication Strategies for Diverse Populations.* Washington, DC: National Academies Press; 2002.

14. Resnicow K, Braithwaite R. Cultural sensitivity in public health. In Braithwaite R, Taylor S, eds. *Health Issues in the Black Community.* 2nd ed. San Francisco, Calif: Jossey-Bass; 2001: 516–542.

Confronting Health Inequity: The Global Dimension

Since the days of Hippocrates, health inequities and the role of social and environmental factors in the determination of marked differences in health status have been well recognized. For some time now, the driving force behind public health has been understanding and intervening in the underlying causes of health inequity. The publication of the Black Report[1] in the United Kingdom in 1980 brought a more focused approach to this discourse by identifying specific factors, such as social class, gender, and race/ethnicity, as the social and economic determinants of health inequities. With this evolution came a conceptual and operational distinction between health disparities/inequalities and health inequity/equity.[2]

These distinctions aside, the issue of health inequity has moved beyond the academic discourse into the arena of policy and action. In the United States, the 2002 Institute of Medicine report *Unequal Treatment: Confronting Health Care Disparities* marked a turning point.[3] It is, however, important to recognize that like the problem of health inequity itself, the struggle to confront it is neither unique to the United States nor simply a local matter. Many nations, both developed and developing, have adopted strategies to reduce health inequities.

EFFORTS IN THE DEVELOPED WORLD

Confronting health inequities is increasingly a priority for