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Communication and Racial Inequities in Health Care

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There are striking inequities in health outcomes between racial and ethnic groups in the United States, with many groups experiencing significantly poorer health outcomes than members of the racial majority, White (non-Hispanic) health care consumers. These disturbing health disparities exist even when controlling for differences in income and health insurance. Racial disparities in health outcomes are related to communication problems within the health care system, which lead to unequal access to health information and inadequate participation in health care decision making. Specific strategies for improving health communication to overcome these problems and to help reduce disparities in health outcomes are suggested.

Keywords: *health disparities; health outcomes; communication; health promotion*

The Racial Health Disparities Problem

There are alarming inequities in health outcomes between different racial and ethnic groups in the United States, with many minority groups, especially African Americans, experiencing significantly more serious health problems, such as higher rates of morbidity and mortality, than members of the racial majority, White (non-Hispanic) American health care consumers (Bach et al., 2002; Fiscella, Franks, Gold, & Clancy, 2000; Institute of Medicine, 1999, 2003; Lannin et al., 1998; Ward et al., 2004). These disturbing health disparities exist even when controlling for differences between racial groups in income and health insurance (Woolf, Johnson, Fryer, Rust, & Satcher, 2004). For example, a recent in-depth analysis of health outcomes data suggests that more than 886,000 deaths of African Americans could have been prevented from 1991 to 2000 if these African American health care consumers had received the same quality of care as non-Hispanic White consumers (Woolf et al., 2004). Racial health disparities are recognized as a significant public health problem in the United States, and although government agencies have developed aggressive programs to help narrow these serious inequities, the disparities remain acute (Bigby & Pérez-Stable, 2004; Freeman, 2004; Keppel, Pearcy, & Klein, 2004; Lee, 2001; Ward et al., 2004).

Health disparities cross a range of different health risks and diseases. The two major known causes of mortality for African Americans are heart disease and cancer, followed by stroke, the same as for non-Hispanic Whites, although the risk factors and

incidence, morbidity, and mortality rates for these diseases are generally far greater among African Americans than for non-Hispanic Whites (Centers for Disease Control and Prevention, 2005). Stroke is the third leading cause of death for both non-Hispanic Blacks and non-Hispanic Whites, although Black males and females aged 20 to 74 years had much higher age-adjusted mortality rates from stroke than their White counterparts (36.8 vs. 23.9 for males; 39.4 vs. 23.3 for females; Centers for Disease Control and Prevention, 2005). Even with dedicated long-term national health promotion initiatives such as the U.S. Department of Health and Human Services' Healthy People 2000 and Healthy People 2010 programs that target the reduction of health disparities, African Americans and many other minority groups still face serious health disparities. For example, African Americans have both the highest rates of infant mortality and the highest incidence of diabetes of any U.S. racial or ethnic group (Keppel et al., 2004). Wong, Shapiro, Boscardin, and Ettner (2002) reported that in addition to heart disease and cancer, hypertension, HIV, diabetes mellitus, and trauma were significantly large causes of mortality among African Americans. In fact, diabetes, which has been increasing at an alarming rate in the United States, poses a significantly greater mortality risk factor for African Americans than for non-Hispanic Whites (Centers for Disease Control and Prevention, 2005). "The life expectancy of African Americans has been substantially lower than that of white Americans for as long as records are available" (Kunitz & Pesis-Katz, 2005, p. 5). These significant racial inequities in health outcomes must be addressed to promote public health in the United States.

Cancer-Related Health Disparities

Although serious disparities in health care outcomes cross a number of different health risks and disease states, cancer-related health outcomes are a significant area of concern. African Americans carry the highest cancer burden among any of the U.S. racial and ethnic groups (Ghafoor et al., 2002). Cancer is the second leading cause of death for both Blacks and Whites in the United States, although cancer incidence is substantially higher for Black females than for White females for colorectal cancers (54.0 vs. 43.3), pancreatic cancers (13.0 vs. 8.9), and stomach cancers (9.0 vs. 4.5) and higher for Black males than for White males for prostate cancers (251.3 vs. 167.8), lung cancers (108.2 vs. 72.8), colorectal cancers (68.3 vs. 58.9), and stomach cancers (16.3 vs. 10.0) (Centers for Disease Control and Prevention, 2005; Hoffman et al., 2001). (Many of these cancers are linked to lifestyle factors including diet, exercise, alcohol use, and tobacco use.) Although cancer incidence rates are unrepresentatively high for African Americans, the real inequity is not just in cancer incidence but also in cancer mortality rates, because African American consumers die at an alarmingly higher rate from many cancers than other racial and ethnic groups. For example, Shavers and Brown (2002) reported that African Americans have a 33% higher risk of dying from cancers than Whites do.

> Advances in early detection, screening, and treatment have reduced cancer incidence and mortality, improved life expectancy, and enhanced quality of life for many cancer patients. However, when cancer incidence and mortality rates of African Americans are compared with other ethnic groups, African Americans are significantly more likely to develop cancer and, subsequently, die from their disease. (Underwood, 2003, p. 270S)

Furthermore, pervasive and often life-threatening cancer-related health disparities coexist as comorbid conditions with many other areas of health inequities, such as heart disease, diabetes, and stroke, that have devastatingly negative influences on the health of African Americans (Smedley, Stith, & Nelson, 2003).

There are a number of societal contributing factors that may lead to and exacerbate the cancer-related health disparities faced by many African Americans, including poor socioeconomic status, low levels of educational attainment, and racial prejudices toward African Americans (Freeman, 2004; Kinney, Bloor, Martin, & Sandler, 2005; Krieger, 2002; Kunitz & Pesis-Katz, 2005; Lannin et al., 1998). Although the societal issues of poverty, low educational attainment, and prejudice will take concerted long-term efforts to redress, there are many other significant behavioral contributing factors that can be addressed through health communication interventions. These behavioral factors include resistance by many African Americans to adopting recommended cancer prevention behaviors, reluctance to participating fully in suggested cancer screening programs, and inequities in accessing the best cancer care treatments (Jernigan, Trauth, Neal-Ferguson, & Cartier-Ulrich, 2001; Loerzel & Bushy, 2005; Stallings et al., 2000).

For example, current evidence suggests there are significant and entrenched patterns of resistance by many African Americans to adopting cancer prevention–related behavioral recommendations, such as engaging in low-fat, high-fiber, fruit-and-vegetable–rich nutritional practices, adopting regular aerobic exercise regimens, reducing alcohol consumption, eliminating the use of tobacco products, and adopting strategies for reducing the risks of sexually transmitted diseases (Haire-Joshu, Kreuter, Holt, & Steger-May, 2004; Prothrow-Stith, Gibbs, & Allen, 2003; Resnicow et al., 2002). In a similar manner, there are also very low rates of participation by African American consumers in many recommended screening tests for cancers (such as mammography, prostate-specific antigen tests, pap smears, colonoscopy, etc.) that could increase early detection of cancers and increase opportunities for effective cancer treatments (Kinney et al., 2005; Lannin et al., 1998; Oakley-Girvan et al., 2003; Odedina et al., 2004; Sharp, Zurawski, Roland, O'Toole, & Hines, 2002; Williams, Brown, Hill, & Schwartz, 2001).

Epidemiological evidence also shows that there are significant variations in both access to and delivery of the best cancer care for African American patients, including definitive primary therapy, conservative therapy, and adjuvant therapy (Ashton et al., 2004; Bernstein, 2003; Randall & Armstrong, 2003; Shavers & Brown, 2002; Steyerberg, Earle, Neville, & Weeks, 2005). Each of these contributing factors to cancer health disparities is strongly influenced by the quality of health communication in cancer prevention, control, and care (Kreps, 2003).

Racial inequities in cancer-related health outcomes are often caused by insidious communication patterns within the health care system that lead to unequal access to relevant health information between racial groups and encourage low levels of participation by minority health care consumers in disease prevention, health promotion, and health care decision making (Chang et al., 2004; Kreps, 2005a). Relevant health information is a critical resource for health care, and health promotion and communication is the process by which such relevant information is accessed and applied (Kreps, 2002, 2003). By carefully examining the ways that communication problems contribute to cancer-related health disparities, we can suggest specific communication strategies for overcoming disparities by enhancing cancer prevention, screening, diagnosis, treatment, and survivorship for African Americans and other groups that suffer from health disparities (Kagawa-Singer, 2001; Kreps & O'Hair, 1995; R. Parker & Kreps, 2005; Taylor & Lurie, 2004).

Communication and Cancer Care

Communication is central to the provision of high quality cancer care across the continuum of care: prevention, screening, diagnosis, treatment, survivorship, and end of life (Hiatt & Rimer, 1999; Kreps, 2003; Zapka, Taplin, Solberg, & Manos, 2003). A large body of research illustrates that effective health communication, across multiple communication channels and levels, contributes to achieving a range of important cancer-related health outcomes (Davis, Williams, Marin, Parker, & Glass, 2002; Eysenbach, 2003; Kreps, 2003; Kreps & Chapelsky Massimilla, 2002; Liang et al., 2002; Ong, Visser, Lammes, & de Haes, 2000). Strategic health communication processes enable implementation of primary prevention strategies (risk prevention and health promotion campaigns); delivery of secondary prevention (promoting cancer screening and early detection) programs; establishment of accurate and meaningful diagnoses; development of appropriate, effective, and adaptive treatment strategies; coordination of cancer care activities; facilitation of crucial support for successful cancer survivorship; and provision of sensitive end-of-life care (Gittell et al., 2000; Hewitt & Simone, 1999; Kreps, 2003; O'Hair, 2003).

For example, communication is a primary process for promoting cancer prevention and screening through the development and implementation of strategic communication campaigns that identify salient cancer risks and carcinogens for consumers to avoid. Communication helps to promote healthy behaviors (such as refraining from using tobacco products, following a healthy diet, and engaging in a program of recommended regular exercise). It also can encourage consumers to seek appropriate cancer screening tests based on their unique health histories and demographic factors (Gates, 2001; Kinney et al., 2005; Odedina et al., 2004; Viswanath & Finnegan, 2002; Williams et al., 2001). Cancer prevention and detection efforts typically involve the development and distribution of persuasive and informative cancer educational programs and materials, as well as the development of behavioral intervention programs designed to influence often-entrenched health behaviors (see, e.g., Buller et al., 1999;

Marcus et al., 2001; Pierce, Macaskill, & Hill, 1990; Ziant, 1993). Yet evidence suggests that many campaigns have been less than effective in reaching and influencing vulnerable audiences, and concerted efforts must be taken to develop culturally sensitive strategic communication interventions to influence the health behaviors of underserved populations that are heir to disparities in health outcomes (Hornik, 2001; Kreps, 2000; Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003; Loerzel & Bushy, 2005; Marcus et al., 2001; Snyder et al., 2004).

Interpersonal health communication processes are critically important for cancer prevention and care. Interpersonal communication between providers and consumers is central to the diagnostic process, enabling providers to gather key information from consumers about symptoms, to evaluate and make sense of symptoms to develop accurate and timely cancer diagnoses, and to deliver diagnostic information sensitively and meaningfully to consumers and other members of the health care delivery team. Effective interpersonal interaction is essential for providing informed consent to treatment, as well as for collaborative planning and delivery of appropriate cancer treatment strategies (Baile & Beale, 2001; Guttman, 1993; P. Parker et al., 2001; Radziewicz & Baile, 2001; Sapir et al., 2000; Street, 1991; Waitzkin, 1985). Moreover, interprofessional interpersonal communication enables needed coordination between interdependent health care providers in the delivery of cancer care (O'Hair, Kreps, & Sparks, 2005).

Cancer treatment is an active, and ideally, a collaborative communication process where providers and consumers must work together to examine treatment options and develop refinements to treatment strategies to make informed decisions about the best available programs of treatment (Kreps, 2003; Larsson, Widmark-Peterson, Lampic, von Essen, & Sjoden, 1998; Liang et al., 2002; O'Hair et al., 2005; Samarel, Fawcett, Davis, & Ryan, 1998; van der Kam, Branger, van Bemmel, & Meyboom-de Jong, 1998). Current evidence suggests there are significant communication barriers to effective provider-consumer communication in cancer care that limits the effectiveness of health care outcomes (Arora, 2003; Back, Arnold, Baile, Tulsky, & Fryer-Edwards, 2005; Kerr, Engel, Schlesinger-Raab, Sauer, & Hölzel, 2002; Laing et al., 2002). Although serious communication barriers limit the effectiveness of cancer care for all patients, these problems are even more significant deterrents because of insidious intercultural communication challenges to meeting the heath care needs of vulnerable populations that often suffer from disparities in health outcomes (Arbes et al., 1999; Kagawa-Singer & Kassim-Lakha, 2003; Matthews, Sellergren, Manfredi, & Williams, 2002; Sharp et al., 2002).

Strategic multichannel, multilevel health communication can perform a central role in meeting the information and support needs of the growing population of long-term cancer survivors, especially for those individuals confronting end-of-life issues (Kreps, 2003; Rowland, Aziz, Tesauro, & Feuer, 2001). In recent years, as the quality of cancer care has improved, the number of cancer survivors has increased dramatically. Rowland et al. (2001) predicted that in the absence of other competing causes of death, more than 60% of those diagnosed with cancer can expect to be long-term cancer survivors. Cancer survivors have unique information needs to help them cope with

the many uncertainties of living with cancer, including the fear of cancer reoccurring (Gilligan et al., 2003). Survivors also need to access social support and relevant information to help them live with side effects of cancer treatments. Peer support from others who have adapted to living with cancer can often help cancer survivors overcome both physical and psychosocial challenges and enable them to readjust to their everyday lives (Kilpatrick, Kritjanson, Tataryn, & Fraser, 1998; Rowland et al., 2001; Spiegel, 1994, 1995, 1997). Communicating with patients and their loved ones during the end-of-life process is also a very challenging part of cancer care (Curtis et al., 2001; Spiegel, 1997). Death is not easy for most people to communicate about, yet the uncertainties surrounding death demand sensitive and caring communication (Kreps, 1988). The quality of communication at the end of life is critical to providing effective care for terminally ill cancer patients (Baile, Glober, Lenzi, Beale, & Kudelka, 1999; Bruera, Neumann, Mazzocato, Stiefel, & Sala, 2001; Gattellari, Voigt, Butow, & Tattersall, 2002; Larson & Tobin, 2000; Maguire, 1999; von Gunten, Ferris, & Emanuel, 2000). Yet evidence suggests that many intercultural communication barriers limit the exchange of relevant health information and the provision of needed social support to cancer survivors, decreasing these survivors' quality of life and reducing the effectiveness of end-of-life care (Fiscella et al., 2000; Foley & Gelband, 2001; Freeman, 2004; Gilligan et al., 2003; Kreps & Kunimoto, 1994; Marks, Reed, Colby, & Ibrahim, 2004; Ong et al., 2000). Concerted efforts are needed to overcome the communication barriers that reduce the effectiveness of each phase of the continuum of care and lead to significant inequities in modern health care.

Communication Strategies for Reducing Health Disparities

A large body of literature suggests that sensitive, adaptive, and strategic health communication programs and policies can help break down the barriers that contribute to disparities in health outcomes by facilitating the accomplishment of goals within each phase of the continuum of care (Back et al., 2005; Betancourt, Carrillo, & Green, 1999; Kagawa-Singer & Kassim-Lakha, 2003; Kreps & Chapelsky Massimilla, 2002; Taylor & Lurie, 2004; Thomas, Fine, & Ibrahim, 2004). Strategic and sophisticated health promotion campaign messages and materials can help reduce disparities in health outcomes by encouraging adoption of important prevention and screening behaviors by vulnerable populations (Kreps, 2003; Lee, 2001). For public health communication campaigns to be effective, however, campaign messages must be not only carefully targeted to address the most salient cultural factors that influence vulnerable populations but also transmitted via the most salient communication channels for different audiences (Kreps & Kunimoto, 1994; Kreuter & McClure, 2004; Loerzel & Bushy, 2005; Marks et al., 2004; Mohrmann et al., 2000). For example, a number of influential studies indicate that the use of culturally tailored message strategies are particularly effective at influencing cancer prevention and screening behaviors for low-income African American health care consumers, as well as for other

minority group consumers (Champion et al., 2002; Jibaja-Weiss, 2005; Kreuter et al., 2003; Kreuter et al., 2004; Kreuter & McClure, 2004; Saywell, Champion, Sugg Skinner, Menon, & Daggy, 2004). Tailored health communication strategies enable development and delivery of campaign messages that match the unique demographic, cultural, and psychographic perspectives of individual consumers (Dutta-Bergman, 2003; Kreps, 2000; Kreuter, Strecher, & Glassman, 1999). The use of familiar, engaging, and trustworthy communication channels (such as radio and television programs) and the use of personal communication networks (such as in schools, churches, and work organizations) have been shown to be particularly effective campaign communication strategies for reaching and influencing at-risk audiences with health promotion messages (Hornik, 2001; Pierce et al., 1990; Viswanath & Finnegan, 2002).

It is not easy to promote cancer screening to at-risk groups, especially when specific screening strategies (such as colonoscopy or mammography procedures) appear to be uncomfortable and invasive (Gates, 2001; Kreps, 2003; Skinner, Strecher, & Hospers, 1994). Effective health communication campaigns must be strategic and persuasive to overcome audience resistance to promotion and screening goals, encourage personal acceptance of health messages, and reinforce the adoption and maintenance of health promotion and screening behaviors. This can be accomplished only when health promotion strategies are developed to address the wide range of cultural influences on health behaviors in the modern world and designed to meet the unique needs and cultural orientations of vulnerable populations (Hornik, 2001; Viswanath & Finnegan, 2002).

The digital divide is also a significant communication problem that exacerbates health disparities by reducing access to needed health information (Kreps, 2002, 2005a, 2005b). The consumers who are most at risk for poor health outcomes (morbidity and mortality) from cancer and other serious health problems are often members of underserved populations, including those with low socioeconomic status, low levels of literacy, the elderly, members of ethnic minority groups, or those who have limited formal education (Kreps, 2005a). These underserved and vulnerable populations often have limited access to relevant communication channels that deliver key health information, especially information widely available via the Internet (which has become an increasingly important source of health education and support for directing risk prevention, health promotion, and health care decision making; Science Panel on Interactive Communication and Health, 1999).

The same vulnerable populations that are cut off from relevant health information by the digital divide are also subject to serious disparities in health care and generally have much higher rates of morbidity and mortality because of serious health threats than the rest of the public, especially from cancers (Institute of Medicine, 1999; Kreps, 2005a, 2005b). New communication strategies and policies can help underserved populations access and use relevant health information to make informed health-related decisions about seeking appropriate health care and support, resisting avoidable and significant health risks, and promoting their health. For example, the National Cancer Institute recently funded four innovative regional demonstration

research projects, the Digital Divide Pilot Projects, to test new strategies for disseminating computer-based health information to low-income and underserved populations; these projects illustrate the potential for developing effective community-based communication interventions for bridging the digital divide and reducing health disparities (Kreps et al., 2004). In fact, evidence suggests that the most effective interventions for health information dissemination with vulnerable populations have developed culturally sensitive participative community-based collaborations to support sustainable systemic changes in health communication (Dervin, 2005; Kreps et al., 2004; Ma, Fleisher, Gonzalez, & Edwards, 2004; Wood et al., 2003; Zimmerman, Akerekrea, Butler, Hau, & LeBlanc, 2003).

There are also many critically important interpersonal and group communication issues related to improving the quality of health care for underserved populations, especially in ascertaining and presenting diagnoses, making collaborative treatment decisions, providing adaptive follow-up and adjustments to treatment, offering social support, and delivering sensitive end-of-life care (Arora, 2003; Kreps, 2003). Evidence suggests there are significant challenges to effective interpersonal communication in cancer care for vulnerable populations (Collins, Clark, Petersen, & Kressin, 2002; Liang et al., 2002; Ong et al., 2000; Sapir et al., 2000). Several scholars have suggested that public health and human service providers often contribute either consciously or unconsciously to racial/ethnic disparities in health outcomes by expressing cultural biases and prejudicial communication with different racial and ethnic groups (Burgess, Fu, & van Ryn, 2004; Freeman, 2004; Johnson, Saha, Arbelaez, Beach, & Cooper, 2004; Kagawa-Singer, 2001; van Ryn & Fu, 2003). Culturally sensitive health communication, which minimizes the communication of biases, demonstrates respect for others, and helps to develop cooperative health care relationships, has been found to have significant influences on the quality of health care and health promotion with vulnerable consumers (Kagawa-Singer & Kassim-Lakha, 2003; Kreps & Kunimoto, 1994; Kreuter & McClure, 2004). Development of dedicated training programs to promote culturally competent communication for health care participants has shown great promise for improving health communication and reducing health inequities (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Brach & Fraser, 2000; Denboba, Bragdon, Epstein, Garthright, & Goldman, 1998; Langer, 1999; Marks et al., 2004; McNeil, 2003; Taylor & Lurie, 2004). Sensitive and adaptive health communication can also help to overcome health literacy communication barriers that often limit understanding between health care consumers and providers. Care must be taken to use language, examples, and descriptions that all health care participants can understand, as well as to actively seek feedback for assessing current levels of shared understanding for adaptively directing future communications (Davis et al., 2002; R. Parker & Kreps, 2005; Sharp et al., 2002). Health care system policies and programs can also help support effective intercultural communication in the delivery of health care through the development of communication training and support systems, including producing and making available culturally sensitive print, audiovisual, and electronic (often Internet-based) communication materials and information technologies to support health education, treatment decision making, and health

promotion activities (Chang et al., 2004; Kreps, 2002; Mohrmann et al., 2000; Phillips, Mayer, & Aday, 2000). There is much that can be done to improve health communication for reducing health inequities.

Conclusions

Health communication performs a central role in the delivery of health care and the promotion of public health. Communication is the process used to promote prevention of significant health risks, use of healthy behaviors, adoption of early screening and detection procedures, accurate diagnoses, adaptive treatments, successful survivorship, and sensitive end-of-life care (Kreps, 2003). However, breakdowns in communication often cause significant barriers to effective health care and health promotion, particularly for vulnerable populations who suffer from major disparities in health outcomes. Communication training, including the development of cultural competencies, can help health care providers and consumers establish cooperative relationships for sharing relevant information, and coordinating their efforts can help reduce disparities. The development of strategic health promotion and education programs and materials that are relevant and persuasive for vulnerable audiences can help provide at-risk populations with the information and support needed to prevent health problems, identify health problems early when they are most treatable, and seek the best possible care and support. Familiar communication channels, community organizations, and new information technologies can also be used to deliver needed health information and promote informed health decision making. Attention to the development of strategic, adaptive, and sensitive health communication, across a range of communication channels and media, has the potential to enhance the quality of health care and health promotion and to narrow inequities in health outcomes.

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