EDITORIAL

Communication for Better Health

Public health has long employed information and education activities among the efforts to control disease and reduce death. Over time, the scope of such efforts has grown, both as the instruments of communication have expanded and in response to increased knowledge about the origins of contemporary morbidity and mortality. It is estimated that better control of behavioral risk factors alone could prevent between 40 percent and 70 percent of premature deaths. Using effective communication strategies to promote healthy behaviors is, therefore, a vital tool for improving the health status of Americans. This broad understanding of the potential health gains is the basis for communication efforts by the Public Health Service (*1*).

The radical shift in social attitudes toward smoking and the proliferation of health claims in advertising for food products are two broad indicators of the power of health communication. The appeal of a healthy life is making many people change the way they live. As a consequence, significant strides are being made in improving the nation's health profile. Since 1970, the death rate for our number one killer, heart disease, has declined about 33 percent and deaths from our number three killer, stroke, have dropped by 54 percent (*2*).

Careful examination of the nation's progress, however, indicates disparity in the sharing of these hard-earned health benefits among our citizens. Of particular concern is that certain populations, particularly minorities and people with low incomes, carry a disproportionate burden of health problems. Their knowledge and beliefs about disease prevention are also often at variance with those groups enjoying greater health; so too are many of their personal health practices. The desire to improve the health status of all Americans, while ensuring that those facing the highest risks receive special attention, is prompting, among other efforts, special health communication activities to help high-risk individuals, populations, and communities. This special issue of *Public Health Reports* includes evaluations of established communication programs and conclusions from formative research that will be valuable in planning future programs for high-risk populations.

Several of the articles emphasize the importance of carefully defining the population we are trying to reach. Many factors such as socioeconomic status (SES), access to services, and cultural beliefs and values are often coincident with race or ethnicity, and they contribute in fundamental ways to health status disparities among different groups of Americans. Each is important in defining our strategies. In part, an initial challenge is one of clarifying the terminology. "High-risk" is most appropriately related to a specific health problem: gay white males and IV drug abusers are "high-risk" populations for AIDS, the elderly are at "high risk" for falls, young black males are at "high risk" for homicides, and so forth. While high-risk populations are commonly identified as "hard-to-reach," the examples of gay white males and the elderly, among others, show that this is not always true. Freimuth and Mettger's close examination of the literature on "hard-to-reach populations" reveals that the term has often been applied to disparate groups (*3*). The authors challenge health communicators to reassess their concept of the "hard-to-reach" and to adopt more sensitive and interactive approaches.

Most of the papers emphasize the importance of developing audience-centered strategies for understanding and reaching high-risk populations. They provide insights on how focus groups can help us learn more about the various influences that shape these groups' health practices, such as deeply held beliefs about ability to control personal health, family and community supports or barriers, access to credible information, and financial constraints. This sensitive understanding of the barriers and incentives to healthy lifestyles is helpful in designing effective communication activities.

White and Maloney report on market research to uncover the knowledge, attitudes, and beliefs of some "hard-to-reach" high-risk groups (*4*). Focus group results showed that individuals in these groups tended to have a different operational definition of health than that used in health promotion programs. Many believed that healthy behaviors would build their resistance to acute illness, but that chronic diseases, such as cancer and diabetes, were due to fate and heredity and largely beyond their individual control. Consequently, health promotion efforts aimed at these groups must emphasize the interplay of biological risk factors in the family history with behavioral risk factors, such as diet, exercise, and use of addictive substances.

The results of these and other qualitative studies confirm that lack of knowledge is not a sufficient explanation for disparities in health behavior. Health behavior is shaped by personal characteristics, as well as by multiple social and environmental factors. In addition, unique cultural, linguistic, and socioeconomic factors often influence the health behaviors and practices of high-risk populations. Receptivity to information is also influenced by its content and source, as well as the

method and timing of its delivery. When people are directly involved in the process, information translates into learning and action more readily.

Often, key "gatekeepers," such as health care providers, need to be involved: the National Heart, Lung, and Blood Institute invited health professionals to collaborate in the development of the National High Blood Pressure Education Campaign and the National Cholesterol Education Program because many materials and messages pass through them to high-risk patients (*5*). The National Cancer Institute study, reported by Schechter and coworkers (*6*), showed that high-risk women often do not obtain mammograms because their physicians fail to recommend them. These findings confirm the need for communication programs targeting physician behavior.

Media gatekeepers can be vital to health communication efforts. The paper by Arkin summarizes the findings of conferences on mass communication and health (*7*). After identifying the principal barriers and opportunities for improving media coverage of health, conference participants recommended broadening media strategies to include paid advertising; media advocacy and other tactics beyond public service campaigns; increasing awareness within the public health sector of the media perspective on health; working collaboratively with media professionals and organizations, including minority media; and developing guidelines for public-private sector partnerships. Erickson and coworkers review how these strategies influenced the nation's tobacco control efforts (*8*).

If the impact of our efforts is going to be strong enough to register improvements in health outcomes, it is quite evident that we need to leverage the limited resources available for prevention efforts in order to be heard. Partnerships were the key to success in gaining wide dissemination and increased public awareness of the recommendations from the Surgeon General's Workshop on Drunk Driving held in 1988, as reported by the Office of Substance Abuse Prevention (*9*). With limited assistance from Federal agencies and national health advocacy groups, communities were able to generate local media attention for a national story. The National Heart, Lung, and Blood Institute relies on State, local, and community programs to carry out activities that reach individuals on a one-to-one basis and reinforce national messages. Through its national conferences, it maintains and cultivates a network of people who are involved in and committed to the goals of the national programs.

Innovation is demanded if we are to expand the benefits of health promotion and disease prevention to large segments of the U.S. public who were not reached by the efforts of the last decade. We must find ways to tie categorical campaigns to the common theme of personal and community responsibility. Families, jobs, and neighborhoods are both supports and barriers to healthy changes, particularly for people in high risk, hard-to-reach populations. We need a unified approach that reinforces healthy choices, making a healthy lifestyle the norm for the 1990s.

Furthermore, we in the Public Health Service could do a better job of reinforcing our own diverse efforts. People may be confused if they perceive health messages to be competing, even contradictory. With unified strategies and reinforcing themes, our impact could be greatly magnified. While it will always be necessary to compete with powerful commercial influences for the consumer's attention, we should not compete with each other. The articles presented in this issue offer important lessons to each of us in the public health community as we seek to develop the strategies and messages that will enhance the prospects for good health for every American.

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