Pitfalls in health communication: Healthcare policy, institution, structure, and process

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ABSTRACT
The state of health communication for a given population is a function of several tiers of structure and process: government policy, healthcare directives, healthcare structure and process, and the ethnosocial realities of a multicultural society. Common yet specific to these tiers of health communication is the interpersonal and intergroup use of language in all its forms. Language is the most common behavior exhibited by humankind. Its use at all tiers determines quality of healthcare and quality of life for healthcare consumers: patients and their families. Of note, at the consumer end, mounting evidence demonstrates that barriers to health communication contribute to poorer access to care, quality of care, and health outcomes. The lack of comprehensible and usable written and spoken language is a major barrier to health communication targeting primary healthcare costs and sustained health disparities. More research is needed to improve communication about health at all tiers and to develop health communication interventions that are usable by all population groups.

INTRODUCTION
Health communication may be defined as the dissemination of understandable and usable information that concerns itself with health. It is a fundamental ingredient in virtually every form of medicine and health. Health communication is a dynamic process that at any point in time has a status that may or may not be appropriate for specific population groups it is meant to inform. However, measuring the status of health communication for a given population is a complex and ill-defined process.

When conceptualized as a means-end relationship to health status, the complexity of health communication is brought to light. It is the interlacing of government healthcare policy (strategic plans, laws, fiscal commitment, judicial enforcement), institutional directives (healthcare equality and quality oversight), healthcare structure (geographic distribution and access to care, professional education and training, and research priorities), healthcare process (distribution of services, information and its dissemination venues, targeted patient education campaigns, and interpersonal and intergroup encounters) and ethnosocial realities (linguistics, health beliefs, socioeconomic status, and literacy) that influences healthcare utilization, satisfaction, compliance, and public health status at the national and community levels.

The relationship between these many variables has been inadequately studied yet represents an important component of a national healthcare infrastructure and strategic plan that aims to bring quality and equality to the health of all populations. Giving more attention to this conundrum is crucial since the linguistic processes that determine health communication at all tiers shape and define health policy, public health directives, healthcare delivery systems plans, community driven health campaigns, interpersonal encounters, the quality of care, consumer satisfaction, and healthcare expenditures.

The importance of this is exemplified by the recent surge in the literature on readability of health-related documents and health literacy of vulnerable populations. Researchers have pointed out that the readability of health information does not match the literacy skills of the general population and that language barriers and limited proficiency are looming in the most frequently used languages nationally: English and Spanish. Though limited English proficiency typically characterizes those
who speak other languages, this may be an erroneous concept. Nationally, educational attainment is worse for vulnerable populations who speak English; therefore they are limited in their proficiency in the use of the English language as well. The result is limited and ineffective health communication campaigns targeting these populations.

These limitations affect the dissemination as well as the retrieval of health-related information. Of note is the disparity in health information dissemination and retrieval for vulnerable populations, including immigrants, racial/ethnic minorities, the chronically ill populations, and persons over the age of 65 years, who tend to have limited English proficiency and/or limited literacy skills. Poor health communication is also known to contribute to low participation in research, an important factor contributing to sustained health disparities. Poor health communication is also known to contribute to low participation in research, an important factor contributing to sustained health disparities.

**Health communication and health policy**

Communities in poverty, the uninsured, racial/ethnic minorities, persons over the age of 65 years, and the chronically ill are vulnerable populations who shoulder the greatest burden of chronic disease, morbidity, and mortality. However, they are least apt to benefit from written health communication despite having the greatest need, since they are more likely to have less educational attainment and limited literacy skills than the general population. This is especially true of immigrants, racial/ethnic minority groups, and those living in poverty because they experience sustained disparities in quality of healthcare, health outcomes, and health status. The importance of this is demonstrated by the goal of ending health disparities being high on the Healthy People 2010 agenda.

Federal mandates relevant to the provision of culturally and linguistically appropriate health information date to title VI of the Civil Rights Act of 1964. This law is meant to ensure that ‘no person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.’ The Office for Civil Rights (OCR) is charged with enforcing this law and has supported several important litigations that demonstrated Title VI’s relevance to discrimination that results when information is not provided in languages other than English. In addition, the Office of Minority health has recognised the need for cultural and linguistic standards in health communication by releasing 14 standards for culturally and linguistically appropriate health services.

Within the structure of healthcare delivery, quality assurance groups such as the Joint Commission of Accreditation of Health Organizations (JCAHO) and the National Committee on Quality Assurance (NCQA) have issued guidelines for measuring patient information comprehension. Moreover, since 1993, the Federal government has required the inclusion of minorities and women in research funded by them. However, several qualitative and survey studies on research nonparticipation by racial/ethnic minorities have cited the lack of information and inability to understand information about research projects as a key barrier to research participation. This contradicts one of the most important edicts of the Belmont Report on the conductance of research on human subjects, which mandates research participants must receive informed consent that is comprehensible. At the core of these mandates is the provision of readable and comprehensible written information that clearly communicates health-related issues.

Despite this, an important pitfall in health communication policy at all levels is that its language uses the term ‘linguistically appropriate’ as meaning ‘language translation.’ These directives do not address the importance of linguistics per se (readability, word choice, syntax, and idiomatic variation within languages) in health communication but target only the translation of information into other languages.
HEALTH COMMUNICATION AND THE STRUCTURE OF HEALTHCARE

Healthcare delivery systems are fraught with barriers to health communication at all levels. In part, this is due to the paternalistic use of scientific and medical terminology to communicate between systems and between systems and providers, which trickles down to communication between providers and patients. Overcoming linguistic and language barriers in health communication that exist within biomedical healthcare delivery systems is challenging given changing market orientation in an increasingly multicultural society. Linguistic and language barriers are arguably among the most important barriers influencing access to care, access within a healthcare delivery system, quality of care, patient compliance, self-efficacy, and health outcomes especially.32-35

As noted above, healthcare delivery systems are mandated to provide comprehensible linguistically (language translation) and culturally appropriate health information. They have also been given mandates to test comprehension of patient-related documents they provide. However, a major pitfall in the structure of care germane to these mandates is the lack of tools and methods for complying with them. Beyond directives to improve health communication aimed at improving health status, nothing has been offered by federal, organizational, or healthcare quality oversight committees that would help healthcare delivery systems comply with these mandates. Studies that seek to develop standards and tools for developing patient information that is usable by most patients are needed. Of note, these studies must address not only the simplification of written information so that it matches the reading skills of patients, but also its cross-cultural application.

Linguistic barriers also present significant challenges to public safety-net healthcare delivery systems that were established to provide services for the vulnerable members of our society who would otherwise go without healthcare.36 Pitfalls in health communication at the structural (healthcare delivery system) level are exemplified by the Hospital Patient Bill of Rights. In a study of 15 health-related documents used in high volume service areas at a large urban core safety-net hospital system, Spanish translations were available for 14 of the 15. However, in order to read the document for comprehension, reading skills at the college level are needed. Since public hospitals are healthcare safety nets for vulnerable populations who tend to have limited literacy, it is unlikely patients and their significant others will know their rights. Ironically, one of the rights is the ‘right to be informed.’ The major health communication pitfall in the structure of care as it pertains to patients lies in what is erroneously termed ‘linguistic appropriateness,’ which takes into consideration language translation but not other elements of health communication (word choice, syntax, and readability).

HEALTH COMMUNICATION AND THE PROCESS OF CARE

The provision of health information in the preferred language of a person or community may not be as important as ensuring the information provided is comprehensible and that it is provided in a culturally appropriate manner. That is, using language that is common to them and matches their literacy skills. Of note, vulnerable patients, such as those at one of our institutions, tend to have educational attainment at the primary school to less than high school levels.37-39. This means health information provided should have readabilities of 5th grade (the level of children’s books) or lower to be understandable by most populations with low socioeconomic status.

An important and generally recognized component of health communication is cultural competency. This has been described and is accepted as being necessary at the structural (systemic) level as well as at the provider level. Comprehensible dialogue between culturally competent providers and patients is crucial to informing the latter. Patients who are adequately and accurately informed make better decisions that may result in more appropriate health services use, compliance to medical interventions, and reliable self care. In a focus group study, both Latino and African American individuals cited a lack of communication between patients and doctors as a barrier to research participation in research. Latino individuals felt information in Spanish was lacking and that the information that was given to them was not understandable. Both groups also felt that poor communication was one of the main reasons there is fear and mistrust of medical care and medical research, and that communication is better when it with someone from their own race/ethnicity.

An important pitfall in the process of care is use of educational attainment as a measure of the potential comprehension of health information. Since literacy skills diminish with age, they are estimated to be 3-5 grade levels below reported educational attainment.40 Given the preponderance of linguistic barriers that impede comprehension for both English- and non-English-speaking patients’ healthcare delivery systems, investigators and healthcare providers may be denying their patients opportunities to make informed decisions.
about their health and healthcare. This occurs when they provide documents requiring reading skills that do not match patient literacy skills and runs counter to calls to provide linguistically and culturally appropriate patient information in the practice of medicine.

HEALTH COMMUNICATION: THE COMMON DENOMINATOR

Health disparities may be abstractly depicted by an equation where it is the sum of complex interactions of numerous independent variables in the numerator divided by a more concrete yet still complex denominator. The numerator abounds with variables: poverty, unhealthy domestic and community environments, uninsured families, limited educational attainment, limited literacy skills, cultural diversity, lack of cultural competency, traditional health practices and beliefs, and institutional racism, to name some. Should any of these variables increase, the result will be increased health disparities. Health communication is arguably a logical denominator for this equation, since it factors into each variable relevant to the equation’s numerator and germane to the public health. Therefore, improving and/or increasing health communication efforts will diminish health disparities as long as it is not outpaced by the sum of the complex interactions of variables in the numerator. Within this complex equation, there is but one constant: poverty. Other variables notwithstanding, should poverty grow, its influence on all variables will contribute to increased health disparities.

CONCLUSIONS

“Para comunicar información acerca la salubridad con poblaciones pobres efectamente es necesario lograr modos de comunicar comprensiblemente, simplemente, concisamente, y en maneras que son culturalmente apropiados. Primero se a importante desarrollar un dialogo revelente con representates communitarios cuyo percepciones de la salud y realidades sociales no son adecuadamente conocidos o entendidos por los politicos que aproban leyes sin cumplirlas por medio de la judicial que tambien anda sin conocimiento de las problemas que afecta los pobres.”

This passage written in Spanish summarises the theme of this paper. Imagine you, the reader, are a patient given this information under the stress of illness while attempting to access healthcare, during which time it is known that literacy skills diminish acutely. If you do not read Spanish, the information is useless to you. If you read Spanish but have less than college level literacy skills, you will have difficulty deciphering the words, linking them into a cohesive message, and associating them with your experiences. The result is poor health communication, diminished comprehension, possible misinformation that risks your safety and noncompliance to its advice, and, eventually, poorer health outcomes. If this passage were intended to provide you with information about preventing disease, caring for a health condition, or accessing healthcare, then you would miss an opportunity to improve your health.

If the passage were instructions, questions, or response options in a self-administered survey, you may provide answers that are unreliable or may omit responses to items you don’t understand. The result may be the provision of inaccurate or incomplete data to the investigator. If this information is meant to inform policy makers and healthcare delivery systems, they may implement health policy based on misinformation that will not improve the health of your community. If the passage contained information about participating in a research study and what the study entails, investigators may miss opportunities to recruit you into medical research, or you may be participating without being adequately informed of risks and benefits and the protection of your privacy. In the latter case, the investigator and/or their institution would not be meeting certification mandates and would be breaking several laws.

The need for new venues for communicating health to communities at large and patients within healthcare delivery systems affects all population groups regardless of socioeconomic status. However, the greatest impact is felt by the nation’s vulnerable populations. For improved health outcomes to be realized for these populations, a continuous and bidirectional stream of comprehensible and usable health-related information is needed between users of health services and health services delivery institutions. Comprehensible health information improves communication about preventive health, healthcare utilisation, healthcare delivery, use of health measures, and participation in clinical and population-based research. There is a great need for culturally relevant ways of informing and retrieving health information from all population groups. This is especially important for culturally diverse, vulnerable populations and may contribute to ending disparities in health and healthcare that exist for them.

The Spanish passage translates into English as: “In order to effectively communicate information about health to poor populations, it is necessary to achieve methods for communicating in a comprehensible, simple, concise, and culturally appropriate manner. First
it would be important to develop relevant dialogue with representatives from communities whose perceptions of health and social realities are not adequately understood by politicians who pass laws but do not enforce them through the judicial system that is also uninformed about the problems of the poor.” The Flesch-Kincaid readability score for the passage in English is higher than 12th grade.

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