SIDEBAR

The Politics of Health Communications

Christopher A. Cooper

The most important scarce resources in politics are time and attention. Sure, money matters, but savvy politicians can always work their networks to seed, find, or harvest more money. No amount of political savvy or connections can generate more time or attention.

Nowhere is this problem more prevalent than in the area of health policy. Health policy is often highly technical, shrouded in verbiage that is not accessible to the average voter or legislator, and can change rapidly. Combine these problems with the reality that health policy is also extremely important and is the subject of massive lobbying efforts, and it becomes clear that the job of communicating health policy effectively is extremely challenging.

The challenge is even greater in an era of low trust. Trust acts as a lubricant for complicated information. In the absence of trust, each interaction with information has more friction and is more difficult to complete. While trust in institutions has been waning since the early 1970s, the COVID-19 pandemic and related political fallout have reduced trust to levels that border on anemic [1].

Despite the challenges, scholars and practitioners must find a way forward, as health communication is increasingly important to any society, but particularly a democratic republic such as ours where public opinion can still influence public policy. From this vantage point, some citizens' disbelief that face masks can improve public health, for example, is not simply a curiosity; it is necessary to understand and challenge these attitudes to create a better society. Similarly, anti-vaccination sentiment is more powerful in a democratic republic because it will result in politicians who are less willing to pass policies that encourage vaccinations. Effective health communication, therefore, is as critical to public health outcomes as the knowledge upon which it relies.

Anyone even remotely familiar with health communications has seen rumors and misinformation run amok—rumors and misinformation that, left to spread to the wrong hands, can result in bad public policy and poor health outcomes. A well-meaning practitioner might be tempted to simply try to quash those rumors by directly refuting them. Unfortunately, as political scientist Adam Berinsky demonstrates in a piece in the *British Journal of Political Science*, attempting to publicly quash rumors may actually make matters worse, increasing the prevalence of rumors and misinformation by drawing attention to them [2]. These results follow from other work on misinformation in American politics. A series of papers by political scientist Brendon Nyhan and colleagues demonstrate that correcting misinformation, particularly on controversial, value-laden issues, can generate backlash [3]. The result of that backlash may be that some people will hold onto their misinformation more tightly after being corrected [4]. Nyhan's work also extends to health policy and health communications [5]. For example, he and his colleagues find that correcting misinformation about the Zika virus in Brazil does not seem to change behaviors. Corrections made by people or resources from the opposing party are particularly ineffective and are the most likely to produce

errors when working with so much information from multiple outside sources. When that happened, we acknowledged mistakes, shared what happened, and updated our dashboard. Finally, data need context. Secretary Cohen became famous for her "data days," when she walked the public through the numbers, explaining trends and implications.

Media is an important channel for sharing information but can't be the only one. Your partners can help disseminate information. We went old school and used a "phone tree" model. There was no master list of all NCDHHS stakeholders, so we had to get creative fast. We identified which staff "owned" which stakeholder groups and put that person in charge of dissemination. One person was charged with dissemination to child care and early learning partners, another to legislators, another to higher education, and so on. The communication office wrote regular updates that were sent to more than 40 staff who then sent the updates to their lists. It wasn't high-tech, but it was efficient, and it worked.

Sharing information only works if people understand it. Too often the COVID-19 information coming from national sources was convoluted, confusing, and full of jargon. Our mantra was: simplify. Our 3Ws and Spanish-language las 3Ms are an example. We asked our health experts to name the top three behaviors—not everything!—people could do before vaccines were available to slow the spread of COVID-19. They told us: wear a face covering, practice social distancing, and frequently wash hands. That was the impetus for **W**ear. **W**ait. **W**ash. (Usa una **M**ascarilla. **M**antén la distancia. Lávate las **M**anos.)

Recommendations for public health leaders and communicators: *Communicate! Do the interviews. Publish content on your channels. Keep your stakeholders informed. Get creative. Share what you know, and what you don't know yet. Don't sacrifice understanding for precision.*

Do the Research

Research is fundamental to health care. It drives the development of new medicines, vaccines, surgical proce-

negative outcomes [6].

So, what is to be done?

There is some evidence that norming behavior among like-minded people can help—at least in the short run. For example, reminding Republican skeptics that prominent co-partisans support masking, or reminding anti-establishment liberals who are vaccine skeptics that many of their co-partisans support vaccinations, can help shift public opinion and be less likely to backfire. In a piece in the *New England Journal of Medicine*, Richard Baron, M.D., and the aforementioned Berinsky argue that "intentionally recruiting civic-minded people to deliver medical and scientific facts that run counter to the public's expectations of those people's own interests might be effective" [7].

As this issue of the *North Carolina Medical Journal* demonstrates, we are living in an area of low trust, and that trust is unevenly spread throughout society. Some people trust more than others and some sources are considered more trustworthy than others. To make matters even more difficult, the specifics of who trusts whom can vary by background, political affiliation, and ideological outlook.

It is not enough for practitioners who wish to accurately communicate difficult information about health and health policy to simply "speak truth to power" and expect outcomes to change. Instead, they must cultivate a heterogeneous network of policymakers and influencers to make the case for them.

From this perspective, health communication in a time of low trust needs to be thought of as a critical process, not a single, invisible act. Research outcomes and preferred health policy must make it from the researcher to a diverse network of sources, who then speak to their respective communities.

Paying attention to the reality of the low-trust environment, the highly technical nature of health communications, and the fleeting nature of public attention is the only way to achieve the policy and public health outcomes that will ultimately benefit society. NCMJ

Christopher A. Cooper, PhD Madison Distinguished Professor of Political Science and Public Affairs, and director, Public Policy Institute, Western Carolina University, Cullowhee, North Carolina.

Acknowledgments

Disclosure of interests. The author reports no conflicts.

References

1. Jones JM. Confidence in U.S. Institutions Down; Average at New Low. Gallup. Published July 5, 2022. Accessed on March 7, 2023. https://news.gallup.com/poll/394283/confidence-institutions-down-average-new-low.aspx
2. Berinsky AJ. Rumors and health care reform: experiments in political misinformation. *Br J Polit Sci.* 2017;47(2):241–262. doi:10.1017/S0007123415000186
3. Nyhan B, Reifler J, Ubel PA. The hazards of correcting myths about health care reform. *Med Care.* 2013;51(2):127–132. doi: 10.1097/MLR.0b013e318279486b
4. Nyhan B, Reifler J. When corrections fail: the persistence of political misperceptions. *Political Behavior.* 2010;32:303–330. https://doi.org/10.1007/s11109-010-9112-2
5. Nyhan B, Reifler J, Richey S, Freed GL. Effective messages in vaccine promotion: a randomized trial. *Pediatrics.* 2014;133(4):e835–e842. doi: 10.1542/peds.2013-2365
6. Carey JM, Chi V, Flynn DJ, Nyhan B, Zeitzoff T. The effects of corrective information about disease epidemics and outbreaks: evidence from Zika and Yellow Fever in Brazil. *Sci Adv.* 2020;6(5):eaaw7449. doi: 10.1126/sciadv.aaw7449
7. Baron RJ, Berinsky AJ. Mistrust in science—a threat to the patient-physician relationship. *N Engl J Med.* 2019;381(1):182–185. doi: 10.1056/NEJMms1813043

Electronically published May 1, 2023.

Address correspondence to Christopher A. Cooper, 1 University Dr, Dept of Political Science and Public Affairs, Western Carolina University, Cullowhee, NC 28723. (ccooper@email.wcu.edu).

N C Med J. 2023;84(3):157-158. 0029-2559/2023/84308

dures, and behaviors. So, it's shocking how little is invested in how to best communicate health information so that people take the desired action. This needs to change.

North Carolina was among the first states—if not the first—to conduct comprehensive, values-based research to understand how people would make decisions about COVID-19 vaccinations. Working with Neimand Collaborative and Artemis Strategy Group, we conducted statewide research to uncover the benefits, emotions, and values needed to create behavior change. These insights allowed us to build a campaign that understood people's motivations, respected their fears, accounted for the barriers they faced, and created culturally aligned outreach that provided people with confidence to get vaccinated.

Understanding how people make health decisions drives the most efficient and effective use of resources. In the case of COVID-19 vaccines, we learned that while reasons for hesitancy differed across demographic groups, the motivating messages were the same: it was the messenger that mattered. This finding was counterintuitive to many working on the response, who believed that the wide range of experiences across populations—and particularly the injustices experienced by historically marginalized populations—required segmented messaging. Having the research to point to, and having our research team present the findings to groups across the state and answer their questions, kept us from diverting the time and money that would have been needed for segmented campaigns.

Recommendations for national and state public health leaders: *Invest in market research and let states and communities know that you are doing it. Research and understand how people make decisions rather than relying solely on message testing. Understand what people value and the trade-offs they make in deciding on behaviors. Share the findings broadly and specifically with those charged with communication. Let people ask questions so they have confidence in the findings. Provide*