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Bridging Health Disparities through Communication Empowerment and Health Equity: The Theoretical and Practical Trajectory of Gary L. Kreps

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Abstract

Inequalities in health information access represent a critical driver of global health disparities. This paper examines the theoretical and practical contributions of Professor Gary L. Kreps, a pioneering figure in health communication scholarship. Through analysis of his work on patient empowerment, information-seeking behaviors, and vulnerable populations, this study illuminates Kreps's communication-centric approach to healthcare practice. The analysis demonstrates that enhancing provider-patient interaction, building health literacy, and addressing the digital divide are essential components of communication empowerment. These insights provide a theoretical framework for reducing health inequalities and advancing equity through strategic communication interventions.

Keywords

Health Communication; Communication Empowerment; Health Disparities; Health Equity; Gary L. Kreps

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Introduction

Contemporary healthcare is characterized by a profound paradox: while medical technology and pharmaceutical innovations have advanced exponentially over the past half-century, equitable distribution of these benefits remains elusive. Health disparities—defined by the Centers for Disease Control and Prevention (CDC) and Healthy People 2030 as preventable differences in disease burden, injury, violence, or opportunities to achieve optimal health experienced by socially disadvantaged populations—persist globally (CDC, 2011; Healthy People 2030, 2020). These disparities are not merely biological phenomena; rather, they emerge from complex interactions among social determinants including socioeconomic status, educational attainment, geographic location, and racial or ethnic identity (Healthy People 2030, 2020).

Within this intricate web of determinants, inequalities in health information access and communication competence constitute a central yet often underappreciated mechanism driving these disparities. When particular population groups struggle to access reliable health information, lack digital literacy to navigate electronic health systems, or cannot effectively communicate their medical needs to providers, their disease burden increases disproportionately. Ineffective communication in medical contexts undermines prevention efforts, reduces treatment adherence, and ultimately deepens health inequities (Kreps, 2006). Consequently, the question of promoting health equity through communication empowerment has shifted from peripheral concern to central focus in public health scholarship.

This paper explores this critical intersection through the intellectual trajectory of Professor Gary L. Kreps. As Distinguished Professor of Communication and Director of the Center for Health and Risk Communication at George Mason University, Kreps is widely recognized as a founding figure in the modern discipline of health communication (Kreps et al., 1998). Over five decades, his scholarship has provided the theoretical architecture for understanding healthcare not as a series of biological interventions, but as a fundamentally social and communicative process. By examining his contributions—from institutionalizing the field and advancing transactional models of care to developing the Relational Health Communication Competence Model (RHCCM) and evaluating large-scale telehealth interventions—we construct a comprehensive framework for understanding how communication serves as a lever for patient empowerment and reduction of health disparities.

Paradigm Shift: Constructing Health Communication through a Relational Lens

To appreciate the magnitude of the late 20th-century shift in healthcare thinking, we must first understand medical practice prior to the 1970s. During this era, the dominant paradigm of the doctor-patient relationship was characterized by medical paternalism. In this model, physicians were viewed as sole possessors of knowledge and agency, while patients were cast in passive, compliant roles. Communication was understood instrumentally—as a mere mechanism for delivering directives—rather than constitutively, as a process shaping health outcomes (Kreps & Thornton, 1984). Academic inquiry into these dynamics was sparse and largely anecdotal. While medical sociology had begun exploring the sick role, the specific mechanics of interaction—how verbal and nonverbal cues affect diagnosis, trust, and adherence—remained largely absent from medical curricula.

During his graduate studies, Gary L. Kreps identified a critical gap in the social sciences: while interpersonal and organizational communication were burgeoning fields, their application to the high-stakes healthcare environment was virtually nonexistent. In 1974, recognizing the need for formalized investigation of these phenomena, Kreps collaborated with a small cohort of scholars from interpersonal communication, journalism, and public health to establish a dedicated interest group within the International Communication Association (ICA), the world's premier academic body for communication research (Kreps et al., 1998). This initiative faced considerable skepticism. Traditionalists in both medicine and communication studies questioned whether health communication warranted recognition as a distinct sub-discipline. However, the group persisted, arguing that the unique constraints of medical contexts—high uncertainty, intense emotionality, and power asymmetry—demanded specialized theoretical tools. In 1976, two years after its formation, the ICA officially elevated the group to divisional status.

A foundational intellectual contribution of Kreps's early work was his systematic critique of linear transmission models dominating medical thinking. The hypodermic needle or magic bullet theories of communication, derived largely from the Shannon-Weaver mathematical model of the 1940s, conceptualized communication as unidirectional: a sender (the doctor) encodes a message (diagnosis/prescription) and transmits it to a receiver (the patient). Kreps argued this model was fundamentally flawed when applied to human health. It presumed that clearly sent messages would be accurately received, ignoring the noise inherent in medical encounters: the patient's fear, cultural background, literacy level, and conflicting values. In the linear model, patient non-adherence was framed as receiver failure rather than interaction failure (Kreps, 1988).

Drawing on cybernetics and systems theory, Kreps proposed that medical communication must be understood as a transactional process (Kreps, 1990). In transactional models, the distinction between sender and receiver dissolves. Both provider and patient simultaneously send and receive messages. The physician delivers verbal instructions while simultaneously receiving nonverbal feedback (confusion, anxiety, pain) from the patient. This shift carries profound implications for care delivery, redefining the medical encounter's goal from information delivery to shared meaning creation. As Kreps famously stated, health communication is the central social process in the provision of health care and the promotion of public health (Kreps et al., 1998). In the transactional view, health information is not a static commodity to be transferred; rather, it is dynamic and co-constructed. A diagnosis of diabetes, for example, carries no fixed meaning; its significance is negotiated through interaction. To a physician, it may signify glycemic targets; to a patient, it may represent loss of cultural identity related to food, or fear of amputation based on a family member's experience. The transactional model posits that effective care occurs only when these divergent meanings are aligned through dialog.

Central to Kreps's transactional approach is the concept of feedback. In cybernetics, systems maintain stability (homeostasis) through feedback loops. Kreps applied this principle to both the human body and the healthcare team. A patient's body provides feedback through symptoms; the patient communicates these to the doctor; the doctor provides an intervention; the patient offers feedback on the intervention's effects. If communication channels are obstructed—if the patient feels too intimidated to report intolerable medication side effects—the feedback loop breaks. The system cannot self-correct, and health outcomes deteriorate. Thus, Kreps framed communication competence not merely as being nice, but as a functional requirement for homeostatic regulation of health (Kreps & Thornton, 1992). Without effective communication, diagnostic feedback loops fail, rendering even the most advanced medical technologies ineffective.

As the field matured, the need evolved from general transaction theories to specific, testable models. In 1988, Kreps published a landmark paper in the Southern Speech Communication Journal titled Relational Communication in Health Care, introducing the Relational Health Communication Competence Model (RHCCM) (Kreps, 1988). The RHCCM responded to healthcare fragmentation by positing that relationship quality between provider and consumer serves as the primary predictor of health outcomes. The model operates on the premise that healthcare is inherently characterized by high stress and uncertainty. In such environments, humans require social support and orientation. The model is often visualized as a wagon wheel, with the patient at the hub and various healthcare providers (physicians, nurses, pharmacists, technicians) at the spokes. The wheel's structural integrity depends on the strength of these spokes—the communicative relationships (Kreps, 1988). If the relationship between patient and oncologist is strong, but the relationship with the pharmacist is weak, the wheel collapses (e.g., medication errors occur).

Patient Empowerment: From Passive Compliance to Collaborative Decision-Making

Historically, the medical model emphasized compliance—the extent to which patient behavior aligns with medical advice. The term itself implies obedience and submission. In contrast, Professor Kreps's research trajectory charts a decisive shift toward empowerment. Patient empowerment is defined as the process enabling individuals to gain control over their lives and increase their capacity to act on issues they define as important (Kreps, 2011). In healthcare contexts, empowerment encompasses two critical dimensions: the right to be informed (informational empowerment) and the right to participate in decision-making (decisional empowerment).

Kreps has consistently argued that relevant health information constitutes the most vital resource in healthcare (Kreps, 1988). Without information, agency becomes impossible. However, mere information availability is insufficient; it must be accessible, comprehensible, and culturally relevant. This insight drove Kreps's involvement with the Health Information National Trends Survey (HINTS), a comprehensive surveillance mechanism developed by the National Cancer

Institute (NCI). HINTS data revealed that while the internet democratized information access, a digital divide and literacy gap meant that populations most requiring health information (the elderly, minorities, the poor) were least likely to successfully retrieve and process it (Nelson et al., 2004; Hesse et al., 2005). Kreps argued that healthcare professionals must transition from information gatekeepers to navigators and interpreters. The physician's role includes helping patients filter the information deluge available online and contextualizing it for their specific situations. This requires tailoring—a communication strategy adapting messages to individual needs, preferences, and literacy levels (Kreps & Neuhauser, 2010).

Empowerment culminates in Shared Decision Making (SDM), the practical application of the transactional model. In SDM, physicians contribute expertise on treatments and probabilities, while patients contribute expertise on their own values, lifestyle, and risk tolerance. Kreps's research highlights that for SDM to function effectively, power asymmetry must be actively managed. Patients are often socialized toward deference to medical authority. Therefore, Patient-Centered Communication requires providers to actively invite participation, validate patients' expertise regarding their own bodies, and create safe spaces for questions (Kreps, 1988). When patients are empowered to participate, research shows they experience greater satisfaction with decisions and stronger commitment to treatment plans, leading to improved long-term adherence.

One compelling validation of Kreps's theories on communication empowerment and systems design appears in his evaluation of the Veterans Health Administration (VHA) Care Coordination/Home Telehealth (CCHT) program. This large-scale initiative serves as a benchmark for how communication technology can transform chronic disease management. Facing an aging veteran population with multiple chronic conditions (diabetes, heart failure, COPD), the VHA implemented a system for home-based patient monitoring. The program utilized simple, user-friendly messaging devices and videophones allowing patients to report vital signs and symptoms daily. Crucially, the system functioned not merely as data surveillance but as a communication loop. When a patient reported slight weight gain (indicating fluid retention in heart failure), a care coordinator (nurse) would immediately contact them to adjust medication or diet, preventing a crisis (Darkins et al., 2008).

As healthcare moved online, a new challenge emerged: evaluating whether hospital websites and health portals actually empowered patients or merely served as digital brochures. Kreps, collaborating with Italian scholars Luca Buccoliero, Elena Bellio, and Anna Prenestini, sought to operationalize web empowerment. The team developed the Patient Web Empowerment Index (PWEI), a tool designed to audit healthcare websites based on their capacity to facilitate patient empowerment. It moved beyond assessing mere usability (e.g., do the links work?) to evaluating communicative function.

In studies applying this index to Italian National Health Service (NHS) hospitals, Buccoliero, Bellio, Prenestini, and Kreps found that while many hospitals maintained web presence, few were truly empowering (Buccoliero et al., 2010; Buccoliero et al., 2013). Most sites remained in linear transmission mode—broadcasting static institutional information—rather than the transactional mode required for empowerment.

Data-Driven Approaches: HINTS and the Monitoring of Information Behaviors

The capacity to access and utilize health information is essential for maintaining public health. However, significant disparities exist across populations regarding information channels, capabilities, and trust levels, creating a profound Health Information Divide. To systematically understand public health information behaviors, Gary Kreps initiated and led the Health Information National Trends Survey (HINTS) in 2003. Administered periodically by the National Cancer Institute (NCI), HINTS represents a shift from linear, provider-centric models to complex, multi-directional ecosystems driven by digital technology (Kreps, 2011). It is a large-scale, nationally representative survey designed to monitor how American adults access health information, the channels they utilize, barriers they encounter, and how these behaviors evolve over time. Early HINTS data provided the first nationally representative estimates of this transformation, revealing that 63.0% of U.S. adults reported going online, and among these, 63.7% had sought health information in the previous year (Nelson et al., 2004). These metrics enable researchers to identify groups disadvantaged in information access, thereby providing an evidence base for targeted health communication interventions.

A classic HINTS data analysis focuses on divergence between trust in information sources and actual usage patterns. In the inaugural survey (HINTS 2003), results indicated that physicians remained the most trusted health information source, with 62.4% of U.S. adults expressing strong trust in physician-provided information. When asked about their preferred source for specific health concerns, nearly half (49.5%) identified consulting a doctor as their first choice. However, the survey revealed an intriguing Preference-Behavior Gap: despite emotionally placing greater trust in physicians, behavioral patterns told a different story. When facing actual health queries, 48.6% of respondents turned first to the internet, while only about 10.9% actually contacted a doctor as their initial step (Hesse et al., 2005). In other words, the internet—due to convenience and vast information repositories—has become the first responder for health knowledge, even though the public intellectually recognizes physicians as ultimate authorities.

This phenomenon can be explained by trade-offs between accessible but variable-quality information and professional but high-access-cost consultation. The internet offers immediate gratification, albeit with misinformation risk; conversely, while doctor consultations are credible, barriers such as appointment wait times and costs serve as deterrents. Kreps and colleagues described this online-first trend as a tectonic shift in the health information ecosystem (Hesse et al., 2005). They argued this presents both opportunities and challenges: medical institutions must acknowledge proactive online seeking behaviors by providing accurate digital content to preempt misinformation; physicians must integrate patient-sourced web information into clinical encounters. While physician trust remained robust (67%–70%) between 2005 and 2013, trust in traditional mass media declined precipitously, with television trust dropping from 72% to 46%, further emphasizing the need for providers to serve as interpreters of online information (HINTS Brief 39, 2013).

HINTS also illuminated a significant Digital Divide—disparities in internet use for health information based on demographics. Generally, younger, more educated individuals frequently use the web for health resources, while the elderly, those with lower education/income, and rural residents show lower usage rates. Predictors of trust revealed deep structural disparities; individuals with annual incomes below $15,000 and those with Limited English Proficiency (LEP) were significantly less likely to report high physician trust compared to those earning above $75,000 (HINTS Brief 39, 2013). This suggests that over-reliance on digital channels for health dissemination could further marginalize already vulnerable populations. To address this, during his NCI tenure, Kreps launched Digital Divide Pilot Projects, testing new strategies to disseminate health information via computers in impoverished and minority communities. These pilots, in collaboration with local Cancer Information Services, provided computer equipment and training in community centers to guide residents in finding cancer prevention and treatment information. Results demonstrated that when provided with appropriate infrastructure—including information intermediaries like librarians—vulnerable groups could successfully access necessary health information. These findings suggest that technology itself is not an insurmountable barrier; the key lies in community empowerment and support infrastructure (Kreps et al., 2007).

Under Kreps's advocacy, the HINTS research model expanded internationally to form the INSIGHTS project. China conducted its first HINTS pilot in 2012 in cities including Beijing and Hefei, followed by a national probability survey in 2017 (Hesse et al., 2012). These studies allowed scholars to benchmark Chinese public health information behaviors against U.S. data. For instance, analysis of 2017 HINTS-China data revealed a Channel Complementarity pattern: Chinese audiences often combine informational media (e.g., newspapers/magazines) with entertainment media (e.g., television) to satisfy information needs. Generally, traditional and new media serve as complements; however, a significant substitution effect was observed where search engines appeared to replace newspapers for specific information retrieval tasks, mirroring Western trends but accelerated by China's mobile-first ecosystem (Zhang et al., 2020). Furthermore, demographics predicted channel preference: younger, highly educated individuals leaned toward apps and web sources, while the elderly preferred television. Notably, drivers of active information seeking were consistent across online and offline channels: trust in media, self-perceived health status, chronic disease history, and family cancer history all served as catalysts.

Further comparative studies highlight that the Chinese public relies more heavily on interpersonal channels (family and friends), whereas the American public is more accustomed to autonomous seeking via professional media and the internet. Additionally, Chinese respondents generally rated patient-provider communication quality lower than U.S. counterparts, highlighting issues of strained doctor-patient relations and information asymmetry in China. These findings validate Kreps's view that health communication strategies must be culturally tailored. Based on this, Kreps advocates for a Push-Pull-Infrastructure communication strategy: strengthening the public's Pull capacity (health literacy and search skills) while improving health institutions' Push methods (delivering accessible content). Crucially, he emphasizes the third component, Infrastructure, referring to the human and technical capacity (such as librarians or trained nurses) required to connect scientific knowledge with consumer needs (Nelson et al., 2004). Today, HINTS data is open-access, fueling hundreds of academic papers exploring topics from cancer information seeking to vaccine hesitancy, enriching theoretical frameworks like the Risk Perception Model and Uncertainty Management Theory. Ultimately, communication empowerment begins with ensuring diverse groups can conveniently access trustworthy information and translate it into action—a goal for which Kreps's HINTS initiative provides both the scientific roadmap and success metrics.

Bridging the Gap: Cultural Adaptation and Risk Communication for Vulnerable Populations

Health disparities are often most pronounced among vulnerable populations, including the economically disadvantaged, racial and ethnic minorities, individuals with low literacy, the elderly, rural residents, and immigrants. These groups not only face elevated disease risks and poorer healthcare accessibility but are also entrenched in communication inequality. Barriers such as language differences, low health literacy, and lack of cultural trust impede their ability to access essential medical information and services. HINTS data illuminates the severity of this divide: individuals with annual incomes below $15,000 and those with Limited English Proficiency (LEP) were significantly less likely to report high physician trust compared to those earning above $75,000 or speaking English fluently (HINTS Brief 39, 2013). Furthermore, a profound Preference-Behavior Gap exists; while nearly half of adults (49.5%) identify physicians as their preferred information source, actual behavior shows that 48.6% turn first to the internet, often leaving behind those without digital access (Hesse et al., 2005). Professor Kreps's research and practice remain deeply committed to these populations, striving to narrow health disparities through improved health communication infrastructure.

Health Literacy is defined as an individual's ability to obtain, process, and understand health information. The high prevalence of low health literacy among vulnerable groups means that even when medical resources are available, patients may fail to benefit because they cannot comprehend medication instructions or physician advice. To address this, Kreps advocates for applying Communication Accommodation Theory (CAT). This approach requires healthcare providers to adjust communication styles based on patients' cultural backgrounds, linguistic preferences, and comprehension levels. For instance, when interacting with patients from diverse cultural backgrounds, physicians should avoid medical jargon or localized metaphors in favor of familiar expressions; for those with limited literacy, visual aids, demonstrations, and oral explanations should take precedence over text-heavy materials (Kreps & Kunimoto, 1994).

Kreps collaborated with the Health Resources and Services Administration (HRSA) to develop the Unified Health Communication (UHC) online course. This interactive program integrates modules on health literacy, cultural competency, and limited English proficiency (LEP) services, training thousands of healthcare providers nationwide to better communicate with vulnerable patients. By 2011, over 4,000 professionals had completed the course, which was explicitly designed to operationalize the triad of competence required to serve diverse populations (HRSA, 2011). The course received the Blue Pencil & Gold Screen Award (First Place) from the

National Association of Government Communicators, recognizing its excellence in public education. Kreps emphasizes that adapting communication to the audience is intrinsic to communication equity: information is effective only when understood. If senders do not adapt to receivers' needs, disadvantaged populations will remain perpetually excluded from health knowledge.

Recognizing that macro-level policies often fail to address grassroots needs in a timely manner, Kreps advocates for Community-Based Participatory Research (CBPR)—a method engaging community members in identifying problems and co-designing solutions. During his tenure at George Mason University, he partnered with the School of Nursing on the Advanced Nursing Education Workforce (ANEW) project, focusing on improving healthcare for uninsured immigrant populations in Northern Virginia (Kreps, 2020). Leading a team of multilingual graduate students, Kreps conducted field interviews and focus groups at the Mason and Partners (MAP) Clinics. The study revealed that cross-cultural communication competence determines medical experiences for these vulnerable groups. When providers understood patients' cultural backgrounds and immigrant experiences, and demonstrated respect and sensitivity, patient trust and satisfaction increased significantly. For example, a Latina patient with diabetes noted how a nurse's use of simple Spanish greetings made her feel welcomed, while a doctor used food examples from her home country to explain dietary restrictions, making advice actionable. These details fostered strong therapeutic alliances. The team found that when clinics operate with cultural sensitivity and communication accommodation, they can deliver highly satisfactory services even with limited resources. These findings were integrated into training curricula to optimize clinic services and reported to federal health officials, demonstrating how community-embedded research not only validates theory but directly empowers vulnerable groups (Kreps, 2020).

Health communication must be contextualized. In a multicultural world, identical messages can yield vastly different effects depending on delivery. Kreps recognized this early on, co-authoring the book Effective Communication in Multicultural Health Care to explore strategies across cultural contexts (Kreps & Kunimoto, 1994). The text emphasizes that providers must understand diverse beliefs regarding health and illness, communication etiquette, and linguistic nuances. For instance, stoicism in some Asian cultures may prevent patients from actively expressing pain, necessitating proactive inquiry by physicians; similarly, some Indigenous communities may prioritize traditional healing and elder advice, which health programs must respect and integrate. Kreps cites such cases to remind professionals that cultural sensitivity is an essential skill rather than an optional trait.

Beyond domestic diversity, Kreps is a founding member of the Society for Health Communication, dedicated to connecting practitioners and researchers globally. He actively collaborates with international organizations to host workshops, such as the Summer International Workshop on Health Communication at Beijing Normal University, where he introduced the HINTS paradigm and global trends to Chinese scholars (Hesse et al., 2012). Under his advocacy, a knowledge-sharing network spanning cultures and borders is emerging. This facilitates mutual learning: High-Income Countries (HICs) share mature intervention models, while Low- and Middle-Income Countries (LMICs) contribute effective grassroots strategies developed in resource-constrained settings. Comparative analysis of HINTS-China data has been particularly revealing; while Chinese consumers exhibit Channel Complementarity by using traditional and new media together, recent data suggests a displacement effect where search engines are rendering traditional newspapers obsolete for information retrieval (Zhang et al., 2020). The ultimate goal is to enhance the scientific rigor and local applicability of health communication worldwide, ensuring equitable access to health information for all.

Vulnerable populations are disproportionately affected during public health emergencies; thus, risk communication requires an equity lens. As a member of the FDA Risk Communication Advisory Committee, Kreps wrote and spoke extensively during the COVID-19 pandemic, calling for strengthened information support for minorities and low-income groups. He noted that while the pandemic underscored the importance of public health communication, it also exposed global inequalities in communication capacity. HINTS data suggests that while the general population has moved away from broadcast media, Non-Hispanic Black and Hispanic Americans remain twice as likely to trust television compared to Non-Hispanic Whites, indicating that traditional media remains a vital channel for reaching these specific underserved demographics (HINTS Brief 39, 2013). Some nations (e.g., New Zealand, Vietnam) rapidly deployed culturally appropriate strategic communication, providing relevant, actionable information and mobilizing community responses, thereby keeping infection and mortality rates low. Conversely, other nations suffered from poor communication, leading to rampant misinformation, public confusion, polarization, and unnecessarily high mortality. These failures were often most severe where social inequality was highest: information-poor groups, lacking access to authoritative channels, fell prey to rumors or distrusted government measures.

To counter this, Kreps emphasizes a whole-of-society approach to pandemic communication. He recommends a dual strategy: unified national messages disseminated via mass media, combined with targeted measures for vulnerable communities (e.g., community outreach, multilingual messaging, SMS broadcasts). Furthermore, governments must actively monitor and mitigate the infodemic by partnering with tech companies to curb misinformation. Emerging technologies also play a role; a 2024 Delphi study highlights that while Responsible AI holds transformative potential for personalizing risk communication, it poses risks regarding lack of contextual empathy and potential for generating sophisticated misinformation (Mahl et al., 2024). Only when every individual can timely access scientific knowledge and understand the necessity of action can society build resilience against crises. In a recent review, Kreps concluded that ensuring efficient and equitable flow of health information during crises is a critical dimension of health equity. This insight serves as a call to action for global public health authorities to build communication mechanisms based on equality and trust.

Conclusion

Health Equity entails that every individual possesses fair opportunity to attain their full health potential, necessitating both accessible healthcare services and comprehensible health information. The academic trajectory of Gary L. Kreps demonstrates that while technology and funding are vital, communication and information are equally indispensable in narrowing health disparities. Through decades of rigorous scholarship and practice, Kreps has established a robust theoretical foundation and empirical evidence base for the field, substantiating that effective communication empowers individuals, optimizes medical outcomes, and advances health equity.

First, at the micro level, Kreps focuses on information exchange and relationship building within patient-provider interactions. His work reminds practitioners that patients are not cold clinical cases but human beings with distinct emotional and cognitive needs. A nod, a smile, or a patient explanation can serve as a pivotal turning point in a patient's trajectory. Only when physicians are willing to listen do patients feel safe to disclose; only when patients feel understood does treatment extend beyond the physical realm. Similarly, when patients are equipped with knowledge and granted decision-making power, they are more motivated to adhere to treatment plans and adopt healthy behaviors. This empowerment, rooted in communication, ultimately manifests as improved disease control, heightened patient satisfaction, and strengthened mutual trust.

Second, at the macro level, through initiatives like HINTS, Kreps has mapped the landscape of national health communication, enabling policymakers to identify populations most in need of information support. He emphasizes that public health planning must prioritize vulnerable groups, avoiding one-size-fits-all dissemination that risks exacerbating the knowledge gap—where the information-rich get richer and the poor get poorer. Consequently, tailored and multi-pronged strategies are required: on one hand, developing multilingual media and community education to extend the information acquisition capabilities of lagging groups; on the other, regulating content on mainstream and digital platforms to establish a reliable information safety net against misinformation. Health promotion can truly benefit the entire population only when appropriate health information is accessible to every individual.

Finally, Kreps's cross-cultural endeavors remind us that in an era of globalization, health challenges respect no borders, and issues of information inequality are universal. Whether it is the digital divide in the United States or the urban-rural health literacy gap in China, these are fundamentally symptoms of developmental imbalances. Addressing these issues demands international cooperation and knowledge sharing. By connecting scholars across nations to co-explore solutions, Kreps has set a paradigm for global health communication: we must transcend cultural barriers, draw upon each other's successes, and address shared challenges with collective concern.

In conclusion, the career of Professor Gary L. Kreps is permeated by a singular conviction: Communication Empowerment is the pathway to Health Equity. His scholarly contributions and practical advocacy offer profound insights for healthcare practitioners, policymakers, and communication scholars alike. As the world continues to grapple with various forms of health inequality, we must heed Kreps's counsel: to ground our efforts in science and utilize communication as a strategic tool, ensuring that every piece of health information serves those who need it most. Only then can the vision of health equity be progressively translated into reality.

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