

Health Portals and Menu-Driven Identities

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INTRODUCTION

In this article, we make a case for research which examines the cultural inclusiveness and salience of health portals. We make our case from the standpoint of African-American women. While healthcare should be a ubiquitous social good, health disparities exist among various demographic groups. In fact, health disparities have been placed on the U.S. disease prevention and health promotion agenda. *Healthy People 2010* is an initiative sponsored by policy makers, researchers, medical centers, managed care organizations, and advocacy groups across the country. Although there is no consensus regarding what a health disparity is, sponsors agree that “racial and ethnic minorities experience multiple barriers to accessing healthcare, including not having health insurance, not having a usual source of care, location of providers, lack of transportation, lack of child care, and other factors. A growing body of evidence shows that racial and ethnic disparities in health outcomes, healthcare access, and quality of care exist even when insurance, income, and other access-related factors are controlled.”¹

In addition to healthcare, African American women have less access to the internet. Even at equivalent income levels, African Americans are less likely than either whites or English speaking Hispanics to go online. Demographically, the composition of populations not online has not changed dramatically since 2000. Overall, 60% of the total U.S. population is online with African Americans making up 11% of the total U.S. population, 8% of the online population, and 14% of the offline population. However, when looking at those who are offline, African Americans are more likely than offline whites or Hispanics to believe that they will eventually go online (Lenhart, 2003).

Although online health information is available from multiple sources, we focus solely on those health portals sponsored by the U.S. government. We made this choice based upon some early interviews with physicians and managers at a healthcare facility which serves predominantly African American clients. We learned that most clients exhibited a low degree of trust in information provided by pharmaceutical companies and other sources which seemed too commercial. Instead, clients searched for information from recognizable sources, and tended to use portals and search pages like Yahoo and Google. We found that portals sponsored by U.S. government agencies were received positively by clients. Also, portals like healthfinder.gov and cdc.gov are highly regarded by the Medical Library Association². Moreover, the government is entrusted to uphold values of democracy and social justice therefore the health information that they provide should be accessible to a demographically diverse audience.

To gain insights into the cultural inclusiveness and salience of health portals, we use Nakumara's notion of menu-driven identities. For Nakumara (2002), the internet is a discursive place in which identity is enacted. She uses the term “menu-driven identities” to signify the ways in which content providers represent identities through the design of the interface and the personalization of content, and users perform their identity as they engage with the content. In what follows, we discuss health disparities and the promise of the internet in redressing inequities. Next, we further explain the ways in which users perform identity and health portals represent identities. We do this by theorizing about the health portals as mediating two-way communication between users and information providers. We conclude with directions for future research.

BACKGROUND

Health portals hold promise as an informational source for improving the health of historically underserved populations. This promise is extremely exciting given the state of health disparities in the U.S. We know from prior studies that health provider bias, stereotyping, prejudice, and clinical uncertainty may contribute to disparities along the lines of gender, class, race, and ethnicity (Balsa & McGuire, 2003). For instance, in a study by Bird and Bogart (2001), 63% of survey participants indicated that they had experienced discrimination in their interactions with their healthcare provider because of their race or ethnicity. Similarly, African Americans interviewees reported perceived discriminatory experiences such as inferior treatment, negative attitudes, being treated as if they were unintelligent, being ignored, inappropriate allegations, and racist remarks (Hobson, 2001). These negative experiences may profoundly impact attitudes towards receiving care, and willingness to comply with physician recommendations. For example, Hobson (2001) found that nearly 27% of African American survey respondents reported that, as a result of a discriminatory event, they were more hesitant to seek health services. Others avoided the healthcare facility (25.6%), avoided the provider (23.1%), avoided the personnel involved (10.3%), stopped using specific services (15.4%), or used service less frequently (7.7%).

Computer mediated communication may help minorities, women and other underserved groups to receive healthcare information in a more hospitable climate. The popularity of the internet as a medium for health communication is evidenced in two ways. First, the number of health-related Web sites has dramatically increased from a mere 15,000 sites in 1999 (Rice, 2001) to 100,000 as of 2003 (Cates, 2003). Secondly, although these sources vary in quality and relevance, the number of people seeking online health information rose to 97 million in 2001 from 60 million in 1999 (Rimal & Adkins, 2003). In a 2002 national survey (see Figure 2), researchers found that 73 million people in the U.S. or 62% of internet users have gone online to search for health information. On a typical day, about 6 million Americans go online for medical advice. This exceeds the number of Americans who actually visit health pro-

fessionals according to figures provided by the American Medical Association (Fox & Rainie, 2002). And while 42% of Americans say they don't use the internet, many of them either have been internet users at one time or have a once-removed relationship with the internet through family or household members. In fact, some exploit workarounds that allow them to use the internet by having email sent and received by online family members and by having others in their home do online searches for information they want (Lenhart, 2003). Women are more likely than men to say their latest search was at least in part for someone else—62% compared to 50% of men. Women are also more likely than men to seek healthcare and health information both online and offline (Fox & Fallows, 2003).

Identity

As an increasing number of Americans obtain health-related information online, it is important to consider that the internet is not race and gender neutral. Rather, it is a discursive space in which identities can be represented, performed, swapped, bought, sold, and stolen. Users can create profiles to personalize their experience, and create avatars which serve as visual representations of the body in cyberspace. But while spaces for fluid subjectivity abound, the internet often fails to accommodate minority cultural identities (Kolko, Nakamura, & Rodman, 2000; Kvasny, forthcoming).

Identities are inextricable from communication and are enacted in messages (Hecht, 1993). These enactments transmit and exchange values, beliefs, and norms, which may or may not affirm individuals' or groups' understandings of their own identities (Jackson, Warren, Pitts, & Wilson, under review). Identities also act as interpretative frames in the communication process (Hecht, 1993). Messages are filtered through and made sense of in relation to how individuals perceive themselves. If health messages communicate an identity, which is in conflict with how African American women perceive themselves, then the information may be viewed as unusable and we have done little to combat health disparities. As with all communication, messages that diverge from the identities of minority populations are unlikely to prove effective. Hence, health information must be situated within the target audi-

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