The social embeddedness of health literacy

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Introduction

Health literacy has received great attention as a risk factor or as an asset for health as well as being a powerful mediator of the social determinants of health (Nutbeam, 2008; Kickbusch et al, 2013). Whereas the aspect of mediating social determinants is quite familiar in the recent health literacy discussion, the question of how health literacy itself is mediated, and especially by social environments, is far less the focus of attention. It is helpful, however, that health literacy has already been described as a ‘complex social construct’, which refers to a phenomenon that is not directly observable but shaped by the way it is socially practised (Pleasant, 2014).

Social practice can be seen as an indicator of direction for further debates concerning the conditioning of the social factors of health literacy (see Chapters 36 and 39, this volume). Using social embeddedness as a superior concept, this term encompasses social factors in general and the interplay of compositional and contextual factors in particular (groups, social milieus and material environments). Interestingly, the integrated health literacy definition by Sørensen et al (2012, p 3) highlights ‘people’s knowledge, motivation and competences to access, understand, appraise, and apply health information in order to make judgments and take decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life course’, but does not include a wider perspective concerning non-individual factors. Despite the fact that there are heterogeneous health literacy concepts available focusing not only on the knowledge and abilities of the individual but also on the relatedness of health literacy to the individual and communities’ socioeconomic and socio-cultural context (Parker and Ratzan, 2010; Kickbusch et al, 2013; Sørensen et al, 2015; see also Chapter 18, this volume), the importance of the discussion on social embeddedness has not yet been fully captured. This previously omitted question is an interesting starting point for the following.

Macro-level conditions, for instance, such as a market liberal or neoliberal order, may have an impact on the increasing discussion on health literacy (Bell and Green, 2016). Since, there is reasonable evidence that health literacy is linked to personal health behaviour, health outcomes and health service use as
well as healthcare costs at societal level (Kickbusch et al, 2013, p 47), one may expect that health literacy as a key concept in health promotion is triggered by the interest of cost savings in the health sector. Whether this is so or not, the ideology at macro level is a crucial determining factor that is related to the social embeddedness of health literacy. In this context, the social embedding of health literacy refers to a macro level as well as to micro- and meso-system impacts on the way health literacy is performed.

This way of arguing was already being considered early on by Kickbusch (2001, p 295), but yet to be implemented in the research discussion. This chapter tries to fill this gap. In the subsequent argument, the perspective of social milieus, which directly follows Bourdieu’s social theory, is provided as a missing link in the health literacy debate. This theory import is also linked to the updating of a socio-structural orientation in sociology. This further frame of reference refers to different forms of mentalities and lifestyles, without which we have no understanding of social embedding. A discussion about health literacy cannot do without such an extended understanding of social embedding that refers from the very beginning to an involvement of the social sphere. This applies to the entire lifespan, as illustrated below. The first question is whether health literacy has so far taken sufficient account of social embedding factors in order to subsequently introduce a sociologically oriented perspective of inequality, and to outline the perspective of health literacy research oriented towards social embedding.

**Health literacy as an evolving concept: growing into the social sphere**

From a bird’s-eye view, health literacy can be seen as part of a discussion concerning health promotion. The common goal of both health literacy and health promotion is the maintenance and improvement of health. However, it is important to state that health promotion is the larger unit in the sense that health literacy is a means to promote health and is therefore a component of health promotion. Obviously, they share similar frameworks, but are easy to distinguish regarding aim and range: health promotion’s goal is to promote, maintain or restore health, whereas health literacy’s concern is to access, understand, appraise and apply information to acquire one’s own health or that of others. For a perspective of conceptual differentiation this means that we do not replace or occupy the area of health promotion. The point is that we add a puzzle piece – namely, health literacy – to the overriding framework of health promotion. Finally, health literacy is not an old-wine-in-new-bottle-concept, as previously discussed (Tonks, 2002), but its aims and means are differentiated from health promotion (Wills, 2009). Later on we may see that old bottles are still able to absorb new wine.

Despite the fact that health literacy might be seen as the smaller concept in comparison to health promotion, the ongoing development of the framework suggests an extension of the discussion. Initially focused on care and patient–provider relationships, the concept is now entering a new stage aiming at different
goals that encompass conceptual and theoretical innovations. With regard to an ongoing exceeding of the biomedical and clinical context, this innovative process within the paradigm encompasses first, combining health literacy with the theory of action, which means that health literacy depends on personal agency and environmental factors; and second, understanding the social background plays a crucial role. Emphasising the social embedding and social background of health literacy seems to be evident since health literacy is seen as an ongoing process of capacity building. The latter takes place in a lifelong interaction with the social and material environment, producing substantial abilities, knowledge and skills in individuals:

- Has this reference to the perspective of social embedding been sufficiently reflected in the discussion on health literacy so far?
- Is the health literacy discussion sufficiently referring to the social embeddedness factor?

If we try to approach the issue by asking if a health literacy discussion is referring to the impact of social embeddedness, the answer is, in a real sense, undecided. There are several hints of going beyond the narrow focus of patient–provider relationships, but clearly there is no coherent discussion going on that might be able to feature the whole variety of social science-driven research focusing on social embeddedness. Remarkably, Don Nutbeam (2017) summed up the complexity of health literacy with regard to different environments that require decisions that may be or become health relevant:

“Literacy is not a fixed asset. It is both content and context specific. Although the possession of generic literacy skills in reading, writing and understanding text improves the ability of an individual to access, understand and act on new information, it is no guarantee that a person can consistently apply their skills in situations requiring specific content knowledge, or in unfamiliar settings. In this context, more specialist knowledge and more specific skills may be required. This has led to the recognition of different specialist "literacies", such as financial literacy, science literacy or media literacy. Health literacy can be considered in this context as the possession of the specific literacy skills that are required to make health related decisions in a variety of different environments. (Nutbeam, 2017, p 5)

Mentioning ‘different specialist literacies’ is pointing out that different environments play a role at least if we talk about the performative aspect of health literacy. But what does it mean if we define health literacy hereafter ‘as an observable set of skills that will vary from individual to individual’ (Nutbeam et al, 2017, p 2)? Is that a sufficient specification of individual-to-individual differences? It is not, of course. Considering the existing debate on health literacy’s contexts (‘collective
health literacy'; cf Sanders et al, 2009), public health literacy (Freedman et al, 2009) or context variables are considered as antecedents, influencing factors or determinants of individual health literacy (see, for example, Sørensen et al, 2012). Sociological approaches to describe the interaction of the individual with their environment are used within a health literacy socialisation model (Paek et al, 2011), a socio-ecological model of health literacy for adolescents (Wharf-Higgins et al, 2009) and finally, the health literacy sensitivity of the systems is postulated and a new health literacy flow, the health-literate organisation, was first developed for the healthcare system context and then applied to other health literacies (see, for example, Pelikan et al, 2013; see also Chapters 31 and 35, this volume).

In addition, other approaches occur. A focus sensitive to misinterpretation is highlighted by emphasising the fact that health literacy is part of behaviour change paradigms in public health that focus on persuading individuals to change their habits in an effort to reduce disease propensities. This is not unproblematic, because it is an individualistic understanding of the cause of inadequate health literacy. Above all, the focus on the significance of social inequalities seems to be invisibilised as a result. Blue et al (2016) offer a public health perspective on inequalities that suggests that social theories of practice may provide an alternative access to pressing challenges in dealing with health issues. They still try to avoid a too broad social factor perspective and as an alternative, they focus on social practices in everyday lives:

We highlight the potential and the practical relevance of an alternative social-theoretical tradition: one which views the patterning of daily lives (and their implications for health) as outcomes of the coordination and synchronisation of social practices which persist over time and space, and which are reproduced and transformed by those who “carry” them. (Blue et al, 2016, p 38)

This appears to be an astonishing example for a perspective on social embedding since social practice is not understood as a synonym for individual behaviour, but suggesting that enacting social practices involves ‘the active integration of generic “elements”, including materials/tools/infrastructures, symbolic meanings and forms of competence and practical know–how’ (Blue et al, 2016, p 41). The social practices perspective highlights interactional processes that include a competition and collaboration between practices as well. In Blue et al’s words, it is a position against the individual as a ‘decision-maker’ (2016, p 4). Many approaches do not apply such a social practices perspective (see, for example, Cusack et al, 2017), and consequentially lack complexity in combining the phenomenon (health literacy) with an etiological perspective. Edwards et al (2013) use the term ‘distributed literacy’ to describe how literacy is dispersed throughout a group, and that ‘social support is one of a number of broader factors that influence health literacy, leading to participation in health-care processes and subsequently to altered health outcomes’ (Edwards et al, 2013, p 1182; cf Hamilton, 2010; Sentell et al, 2013). A
network perspective (here referred to as long-term care) is undoubtedly a feature of a social embedding, and this can be shown particularly well by the example of immigrant populations and their networks (Fernández-Gutiérrez et al, 2018).

In The solid facts Kickbusch et al (2013) argue that communities will benefit from the health literacy of their members, and Rowlands et al (2017, p 131) add that ‘health literacy shows strong associations with education, poverty, employment, first language other than the national mother tongue and deprivation of the area of residence.’ Thus, a mutual dependency can be seen while a perspective on the way social factors do influence health literacy is not developed consistently. Sentell et al (2017) were the first arguing in a PRISMA-guided review concerning the context dependence of health literacy that the object in question is defined by a certain multiperspectivity. The latter encompasses different perspectives on the intersection between health literacy and embedding social contexts. Concerning the most common misinterpretation of health literacy as an individual trait independent of social contexts, they argue that most common are association studies combining health literacy and social context variables. The less common studies focus on social context as the ability to leverage a social network to achieve health-related goals. Finally, the least common studies in this area of research encompass health literacy as an aggregated property at a group or network level as well as in a caregiving dyad.

Social embedding, social inequalities and the individual: more of a social science perspective

The question as whether the health literacy discussion is sufficiently referring to the social embeddedness factor cannot yet be answered unambiguously. First, we can state that social context factors highly interact and do not only influence the health-related practices and practice of health literacy. Second, even those approaches that are sensitive to the subject matter (Parker and Ratzan, 2010) still speak of contexts with one focus on medical care and clinical contexts. However, this means a desideratum in the current discourse, and provokes the challenge of an extended concept of context, which should rather focus on the entire range of social embedding.

A social science perspective nowadays encounters a much slower pattern of change in modern societies and their social structures than is commonly assumed by theories of pluralisation, postmodernity and individualisation. Fundamental convictions in the formation of theory, which accept constant change, turned out to be unsuitable. This applies particularly to the subject of social inequality, the structures of social embedding and the assumption of a high degree of autonomous self-control ability of individuals over the dominance of structural effects. The reception of the social theory of the French sociologist Pierre Bourdieu (1932-2002), which is still extensively practised internationally to this day, points the way for social science perspectives in research on the effect of social structures on individual action. Bourdieu developed a synthesising approach, the specificity of
which is not to understand the production and reproduction of social inequalities either purely mechanically, that is, without the involvement of the social actors themselves, or as a result of an arbitrary, almost autonomous, practice. One of Bourdieu’s (1984) major works, *Distinction: A social critique of the judgement of taste*, makes this the starting point of empirical analysis. Bourdieu focuses here on the analysis of objective structures of living conditions (income, educational attainment, etc) as well as on the formation of perceptual, thought and action dispositions of the individuals, and thus on the analysis of subjective (meaning) constructs, motivations for action and individual knowledge. According to Bourdieu, both of these objective structures and dispositional arrangements and the dispositions and modes of action condensed in the habitus form a homology (symmetry) that leads to the stabilisation of inequality and power relations. The underprivileged then form dispositions that hardly allow the questioning of an order recognised as legitimate – even though it discriminates against them.

*Habitus and the social milieu perspective*

For the first time, Bourdieu extensively examined the hierarchical distribution of social power on the subject of everyday aesthetic phenomena such as etiquette, value preferences and mentalities. And today it is abundantly clear that such an extension of the perspective for health issues applies (Dubbin et al, 2013; Blue et al, 2016), especially within social epidemiology (O’Campo and Dunn, 2012), but has not yet been prepared for a connection to health literacy issues. The concept of unequal individual habitus is particularly relevant here. Habitus is considered a product of accumulated, individually experienced and inscribed history in the socialised bodies (in Bourdieu’s sense of internalisation and embodiment of social influences). They are thus in a relationship of equivalence to understand the individual dispositions. The basis for the creation of a habitus is the conditions of social embedding, or spaces of experience, as Bourdieu calls it. Bourdieu describes habitus acquisition in a general sense as a conditioning process in early childhood. Habitus patterns depend on the degree of development and solidification or resistance, depending on the time of their development. The biographically earliest structures, however, have the greatest impact on their lifelong practical application and enforcement.

The perspective of social milieus, which directly follows Bourdieu’s social theory, is linked to the updating of a socio-structural orientation in sociology, which refers to the different forms of mentalities and lifestyles, without which we can have no understanding of social inequality. Interestingly, there is a connection with much older works that refer to the connection between socioeconomic differences and expressions such as language. Thus, the sociolinguistic studies of Basil Bernstein (starting in 1971), in an initially very specific line of research on literacy socialisation, formed one of the most important cornerstones in explaining inequalities, which are reflected both in the social structure and in the mentalities, habits, norms and habitus of different social groups. It was only
through the fact that the Bourdieu analysis categories received a lot of attention in the social science discussion that this discussion was revived. The link with research on divergent educational arrangements is a highly relevant point of contact, and something similar applies to the milieu-specific differentiation of educational styles.

One of the most important attempts to describe lifestyles and literacies in different social structures was made by Annette Lareau (2003). She focuses on educational practices and patterns of parent–child interaction in socially differentiated environments ("unequal childhoods"). Lareau’s ethnographic method, the comparison between poor, working– and middle-class families from a participating perspective, shows clear differences in mentality, which are reproduced in the practices of bringing up children. This makes it particularly relevant to those inequalities in educational behaviour and the acquisition of different literacies that involve different, mostly symbolic, practices (such as language). Lareau describes, for example, the instinctiveness, the social sense, in dealing with the school, the doctor and authorities in the upper echelons of society, and the shame and even the fear and renunciation of the underprivileged milieus when it comes to strategic planning or the assertion of one’s own interests. Lareau thus empirically confirms a traditional pattern of milieu-specific socialisation research, but further differentiates at the level of describing different styles of childrearing. In the upper class she identifies an overarching style pattern of education, which she calls ‘concerted cultivation’. This covers a specific type of parental educational practices aimed at the targeted preparation of children for examinations, preparation for competition and practices that provide social recognition (for example, enough self-esteem to communicate with teachers in school). Lareau’s research and subsequent research approaches thus theoretically come close to Pierre Bourdieu’s theory of inequality and milieu research, because with the mentalities and lifestyles she places the importance of the appropriation of symbolic goods (language, expertise, rules of conduct, incorporated cultural capital, etc) at the centre of the analysis of the impact of unequal life worlds. This sheds light on an important black box in the current discussion, namely, the question of the effects of a different social embedding on individual resources, language, action or motivation patterns.

**Embedding social embeddedness into health literacy research**

Although the question of the determinants of health literacy necessarily arises from the current debate, there is a rather underdeveloped focus on family settings, peers, communities or other forms of contextual and compositional factors. As a consequence, the current discourse does not cover the whole range of the debate. It is overlooked, for example, how in different contexts and depending on social group affiliation, the rationality of action strategies can vary widely. Social milieu research shows impressively how such differences arise under conditions of differentiated social embedding. That also means that the meaning
of health literacy can vary highly from one person, group or geographic (and even historical) setting to another. This is referring to social context factors in general and those concerning social embeddedness in particular. Although the growing of the concept into the social sphere means a more intensive consideration of the social framing of health literacy, it still neglects the contexts health literacy is embedded into in many different ways. Therefore, health literacy has, first, to be understood as a construction that is always socially and culturally embedded into specific practices and events in the everyday life of people, and during the processes of socialisation. Second, analysis and conceptualisations should include the close participation of health literacy users and providers, as these are the main actors with an impact on health outcomes. However, debates within socialisation, literacy and equity research shed light on the significance of differences between people and populations and how these differences lead to different understandings of specific concepts, such as developmental tasks, literacy concepts, educational teaching and learning methods or behavioural aspects in the context of uptake or non-uptake of interventions.

This does not mean that we already have sufficient knowledge to describe the forces of social embedding on the emergence of health literacy. But it is not like we do not know anything, and we cannot ignore related findings from research on learning, habitus, action or motivation. And this also means: neglecting to draw on these related dispositions that are in various ways responsible for the emergence of health literacy may increase the stigmatisation and exclusion of disadvantaged groups who are well known to be the under-achievers in health-related attitudes, knowledge and practice. The following argument includes describing in particular the social embeddedness of health literacy, to show how far social relatedness is important at theoretical and practical levels in the context of health literacy. Therefore, a proposal for an ongoing process of embedding social embeddedness into health literacy research is to use a threefold-oriented approach. This concerns the relationship between social embeddedness and health literacy and includes in brief overview:

• Micro-level of social actors:
  – learning processes and basic skills such as linguistic competence
  – development of basic dispositions (or habitus) of action, including self-efficacy or locus of control beliefs but also lifestyles, resources for action and the availability of capital in the sense of Bourdieu.

• Structural level of organisations and communities:
  – milieu-specific strategies for action, including the priority of embedding health issues into everyday life, parenting styles and knowledge transfer in the family (that is, the knowledge that health can be actively produced)
  – sense of shame in dealing with health or the ability to formulate one’s own health needs vis-à-vis health service providers or facilities that are relevant to health.
• Level of health literacy interventions:
  – knowledge that mistakes can be made in face-to-face communication (including cognitive, motivational or linguistic overload) because subjective barriers are not recognised correctly
  – sensitivity to target group-specific needs and limits on the accessibility of different groups.

Previous Bourdieu reception in the health literacy-related discourse

Differentiation of different levels can only allow a first, heuristic approach. Here, I would just like to point out the extent to which these different levels can be combined with findings from social science research. This applies in particular to Bourdieu’s explanations that are especially relevant for the perspective of the micro and structural level outlined here. In Bourdieu’s social structure model, the space of unequal social positions is structured primarily by the unequal distribution of material and immaterial resources. The differentiation between three primary forms of capital is crucial. Bourdieu distinguishes between: economic capital, characterised by the availability of financial resources; cultural capital, which is (1) in an incorporated (internalised, body-bound) state of skills and competences, (2) institutionalised, that is, mostly legitimised by the educational title, and finally (3) objectified – in short, an objectified form of cultural consumption (goods); and social capital refers to the network of contacts and relationships that can be exploited for personal purposes.

Interestingly, there has been a timid, but perceptible interpretation of Bourdieu’s analysis categories. Adkins and Corus (2009), for instance, try to reconceptualise health literacy as a social and cultural practice. Yang et al (2013) provide a more limited but not uninteresting social capital approach, and Cortelyou-Ward et al (2012) use Bourdieu’s concepts of field and habitus for analysing provider–patient relationships. Dubbin et al (2013) also focus on patient-centred care but give a good starting point for conceptualising what they call ‘cultural health capital’ (as interesting as work by Nduka Uzoma, 2016). Only a few of the younger works (Pinxten and Lievens, 2014) adopt a Bourdieu-based approach in a broader sense of capital differentiation as conditions for action, which seems even more fruitful when it is directly linked to health literacy. In a rather unknown presentation, Smith and McCaffery (2010) try to apply a Bourdieu perspective even in the clinical situation (that is, doctors providing less information to patients with lower education). The most comprehensive approach in this respect is Shim’s (2010) work. This defines cultural health capital as a variety of competencies, attitudes and behaviours, and interactional styles that are responsible for barriers to successful interaction regarding health literacy. Shim focuses on both sides, the culture capital of users and providers, which seems to be well adaptable for the logic of health literacy interventions mentioned in the brief overview of the heuristic approach above. It serves as an indication of the mechanisms of a social dilemma of health promotion, which presumably also affects strategies to
promote health literacy and is associated with the diagnosis of unequal social embedding. In health promotion, the social gap of health inequalities continues in this way: reactive stress syndromes, which accumulate precisely in the lower social situations, do not only have an impact on vulnerability to unhealthy lifestyles that can damage health. At the same time they are also responsible for reducing the responsiveness to an offer of resource reinforcement aimed at increasing invulnerability. The ‘Inverse Care Law’ formulated by Tudor Hart (1971), which is intended to describe the drifting apart of medical care provision from the actual treatment of underprivileged groups, finds its current counterpart in the area of health promotion and highly likely within health literacy promotion itself. If this problem is not recognised and therefore no elaborate understanding of the social embedding of health literacy exists, a development of effective target group-specific strategies cannot take place.

Context matters – but how?

Against this background and by discussing health literacy today, no one would contradict the statement ‘Context matters’. But still, to the question ‘What does it mean exactly?’ no one can give an adequate answer that tells us how context becomes really relevant. With what effect do we have to understand contexts, inequalities and structures or, more generally, social embedding as determinants in the discussion about health literacy? Investigations into the context have so far often been understood as a demand of structures. In other words, contexts function as a structure that makes demands. Also, according to the Parker model, structures are understood as demands while on the individual side there are skills and abilities. However, structures and questions of social integration have so far played little role here. This approach does not seem appropriate to empirical reality. Recent works, including Bourdieu’s socio-theoretical input, suggest an alternative. Such an alternative approach that also takes into account the structural peculiarities at the individual level could be as follows. Based on a well-known distinction in migration research, the structural level associated with focusing on demands could also be described as ‘pull’ factors. While on the structural level associated with focusing on skills and abilities, ‘push’ factors act. ‘Pull’ means that there is an offer that is unequally attractive or can be connected to one’s own needs, competences or abilities. ‘Push’ means one’s own needs, sensitivities, resources or abilities with which one relates to an offer. Immediately understandable to many, much of this argument reminds to understand literacy as literacy practices. In the tradition of NLS, this may indeed be the decisive indicator of why the relationship between health information on the one hand, and the practices of access and use on the other, is not a relation of a rational interaction relationship. The idea that an offer can be used by all users in the same way would correspond to what Bourdieu would call a typical scholastic fallacy – the rational overestimation of social actors or conversely, the confusion of one’s own rationality with that of the objects of observation.
On the other hand, the perspective of social embedding refers to these different conditions under which resources are used or their own rationality of action is applied. From the perspective of a narrow axiomatic logic, one could say that whoever can read and does not adhere to what health-relevant information recommends is incapable. This is perhaps true from such a normative standpoint. However, it overlooks the fact that ‘deviant’ behaviour also follows its own logic of action, which is tied to the rationalities and demands (the push factors) of different social environments. Could one possibly even make from this perspective that there is no inadequate health literacy, but only different forms? An answer to this question is not easy. It provokes a debate on cultural relativism and the no less provocative consequence of *laissez faire* in health promotion. But is that what we want? The answer to this more far-reaching question can only be one that distinguishes between two levels: analytical and political. Analytically, we have to state that we must first understand the different rationalities of action that arise from different forms of social embedding (and associated barriers and limitations). Politically, we can think about how we respond to these insights.

**Conclusion**

As a conclusion and aside from an ideologically overloaded discussion, one must keep sober in argument for a further development of the debate. Who deals with health literacy and does not refer to the social embedding of strategies to act with health issues is widening the health inequality gap. Neglecting the social rendering of dispositions is the first step that leads to the unilateral dissolution of accessibility to good care provision in favour of privileged groups. On the other hand, no matter how rigorously upstream-oriented health promotion is, it is certainly not possible for a society’s health promotion policy to turn its back on the imbalance in the distribution of goods and resources. This level of determinants of health and also that of good practice in health promotion concerning health equity is unattainable. But the possibilities of an at least egalitarian promotion of health literacy must be exhausted. According to Michael Marmot’s ‘proportionate universalism’ ideas, interventions aiming at enhancing health literacy have to address the whole population while putting particular emphasis on people from the most vulnerable social groups (Marmot et al, 2008).

The presented distinction between research activities that refer to the concept of social embedding can be a first step towards integrating social embedding more precisely into the research process. It is clear that the social embedding as a determinant of health literacy has not yet found sufficient space in the discussion so far. Future activities should be focused on the development of health literacy dispositions with a broad analytical focus that includes social embedding and contextual factors. In addition, there is the structural level of embedding in different social environments as well as the independent meaning of the social embedding of interventions that address the behaviour of target groups. All three levels can be an introduction to the clearer consideration of
a significant development perspective of the health literacy concept. The latter refers to exceeding the narrow limits of a research concept mainly focused on the healthcare situation, which has more potential than has previously been unlocked.

References


