

Social cohesion and health literacy

Understanding the concept of social cohesion

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É. Durkheim (4.) was the first to use the concept and terminology of social cohesion at the end of the nineteenth century. In the recent literature several definitions of social cohesion are in use, and it is still debated whether social cohesion is a cause or a consequence of other aspects of social, economic and political life.

Often social cohesion is understood in very general terms. In Canada, the following definition is in use: “Social cohesion is the ongoing process of developing a community of shared values, shared challenges and equal opportunity within Canada, based on a sense of trust, hope and reciprocity among all Canadians.” (Sharon, 20.).

Social cohesion means certainly not simply a homogenous non-diverse society.

Four characteristics of social cohesion are identified in the literature (Beauvais-Jenson,1.):

- it is a process rather than an end state;
- it involves a definition of who is “in” and who is not, to whom members of society owe solidarity, and to whom they do not;
- it is considered to require and be based upon shared values;
- it tends to devote very little attention to the conflicts inherent in any pluralist society, and the mechanisms for their resolution.

There are five dimensions to the concept (Beauvais-Jenson,1.):

- belonging – isolation: that means shared values, identity, feelings of commitment;
- inclusion – exclusion: concerns equal opportunities of access;
- participation – non-involvement;
- recognition – rejection: that addresses the issue of respecting and tolerating differences in a pluralistic society;
- legitimacy – illegitimacy: with respect to institutions.

Beauvais and Jenson (1.), Canadian scientists combine an understanding of social cohesion with social capital and underline the interactive elements of common values and a civic culture; social order and social control; social solidarity and reductions in wealth disparities; social networks and social capital; territorial belonging and identity. This interpretation opens the door to a linkage with contemporary concepts of health.

The European Union has characterised its approach to social cohesion as being consistent with "the European model of society," founded on a notion of solidarity that is embodied in universal systems of social protection, regulations to correct market failures and systems of dialogue.

The Council of Europe's list of defining characteristics includes:

- shared loyalties and solidarity;
- strength of social relations and shared values;
- feelings of a common identity and a sense of belonging to the same community;
- trust among members;
- and reduction of disparities, inequalities and social exclusion.

The Committee of Ministers of the Council of Europe on 7 July 2010:

- defines social cohesion as the capacity of a society to ensure the well-being of all its members – minimising disparities and avoiding marginalisation – to manage differences and divisions and ensure the means of achieving welfare for all members. Social cohesion is a political concept that is essential for the fulfilment of the three core values of the Council of Europe: human right, democracy and the rule of law;

- takes in four aspects of welfare:

- equity in access to rights,
- the dignity and recognition of each person,
- autonomy and personal fulfilment,
- and the possibility of participating as a full member of society;

- assigns responsibility for ensuring the welfare of all to the various stakeholders in society, based on the concept of shared responsibility.

This definition is highly relevant in all of its elements to a better understanding, integrated concept of health literacy, as part of human rights and component of social cohesion.

Social cohesion and health

There is growing interest in health and social sciences literature in the last two decades in looking towards non-economic facets of well-being and social progress, such as health, civic engagement and happiness. Recent outstanding initiatives include the French Government's Commission on the Measurement of Economic Performance and Social Progress (chaired by J. Stiglitz, A. Sen and J.-P. Fitoussi) and the World Health Organization's Commission on Social Determinants of Health (chaired by M.Marmot). These global actions have been triggered by concerns on the level and quality of health and social cohesion in contemporary society, and created new debates between different conceptual approaches in economic and social sciences. These approaches of the relationship between social cohesion and health are far to be ideologically neutral, they reflect basic differences in value choices and in the understanding of scientific competencies.

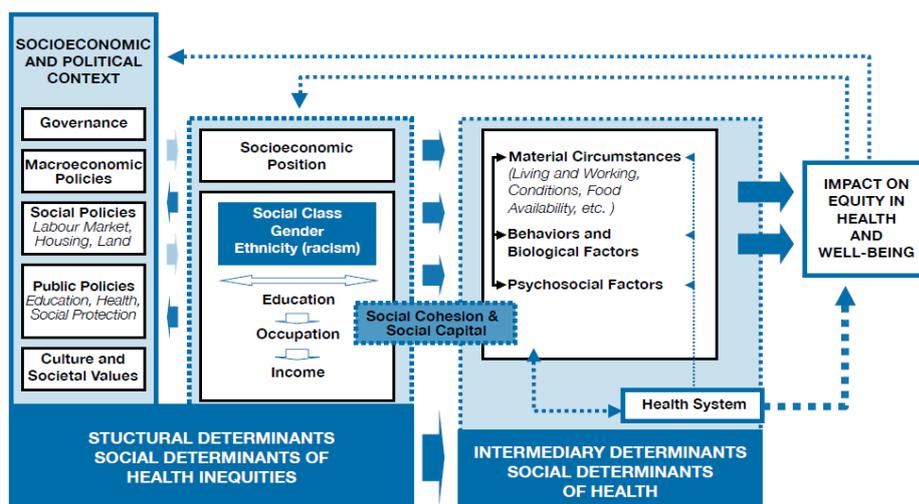
The ability to take collective action for health depends on individuals, who live in the same environment and share a common culture or conditions of life, and develop the collective experience that can strengthen group solidarity for action. The extent to which this awareness, cohesiveness and conceptualisation of common experiences can be developed depend on the cohesiveness and homogeneity of the group or community. More social cohesion is supposed to lead to better health in the community. Good governance may influence or be influenced by both social cohesion and health.

Community/social cohesion is an important objective in its own right. For good governance in health systems its significance goes beyond that. It is one of the key determinants of health and health inequalities. Where conditions are favourable, community cohesion increases social capital and reduces health inequalities and this in turn improves community cohesion vice versa.

According to R. Wilkinson (25.), statistical evidence suggests that social cohesion provides the link between income inequality and health, but it is not clear how it might do so. The author proposes that social cohesion is indicative of underlying psychosocial risk factors that are known to be closely associated with health. According to Wilkinson, “an antipathy between hierarchical relations across inequalities of power, income, and status on the one hand, and supportive social relations between equals on the other, is likely to exert a powerful influence on health”. The results and conclusions of the author have been intensively discussed in recent publications.

According to D. Coburn (2.), “Wilkinson and others believe that, in the advanced capitalist countries, higher income inequality leads to lowered social cohesion which in turn produces poorer health status. I argue that, despite a by-now voluminous literature, not enough attention has been paid to the social context of income inequality — health relationships or to the causes of income inequality itself.” Coburn suggests that there is a particular affinity between neo-liberal (market-oriented) political doctrines, income inequality and lowered social cohesion. Part of the negative effect of neo-liberalism on health status is due to its undermining of the welfare state. The welfare state may have direct effects on health as well as being one of the underlying structural causes of social cohesion. Understanding the contextual causes of inequality may also influence our notion of the causal pathways involved in inequality-health status relationships (and vice versa).

In the Discussion Paper “Closing the gap: policy into practice on social determinants of health” (22.), Solar O. and Irwin A. propose the following model on the system of health determinants:



In this complicated scheme the crucial role of social cohesion bridging structural and intermediary social determinants of health is clearly highlighted, health literacy being part of the psychosocial factors.

Health literacy and social cohesion

At the 7th WHO Global Conference on Health Promotion (Nairobi 2008) a special track has been organised on health literacy. „Health literacy has been defined as the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health. Health literacy means more than being able to read pamphlets and successfully make appointments. By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment.

Defined this way, health literacy goes beyond a narrow concept of health education and individual behaviour-oriented communication, and addresses the environmental, political and social factors that determine health. Health education, in this more comprehensive understanding, aims to influence not only individual lifestyle decisions, but also raises awareness of the determinants of health, and encourages individual and collective actions which may lead to a modification of these determinants. Health education is achieved therefore, through methods that go beyond information diffusion and entail interaction, participation and critical analysis. Such health education leads to health literacy, leading to

personal and social benefit, such as by enabling effective community action, and by contributing to the development of social capital.”(18.)

This broad and innovative understanding of health literacy offers a conceptual bridge with social integration and cohesion.

Health literacy is a multidimensional concept. It includes:

- fundamental literacy,
- scientific literacy,
- civic literacy,
- cultural literacy.

All these dimensions are clearly related to the right to the protection of health, especially to the equity in access to rights, and the possibility of participating as a full member of society in health issues.

According to I. Kickbusch et al. (14.), health literacy skills include

1. Basic health competencies and the application of health promoting, health protecting and disease preventing behaviours, as well as self-care;
2. Patient competencies to navigate the health system and act as an active partner to professionals;
3. Consumer competencies to make health decisions in the selection and use of goods and services and to act upon consumer rights if necessary;
4. Citizen competencies, through informed voting behaviours, knowledge of health rights, advocacy for health issues and membership of patient and health organisations;

The relationships between health literacy and health care are well conceptualised by the model of social marketing blogs (22.):



This scheme highlights the importance of the basic settings of everyday life and social cohesion in the clinical, preventive and navigation aspects of health literacy.

Addressing health literacy enables people to:

- Find, understand, and use the information that they need to stay healthy;
- Get the services and supports they need;
- Make choices in their own lives that help keep them healthy;
- Speak up about their own health needs;
- Have more control over the things that make and keep them healthy.

The impact of limited literacy on different aspects of health and social life has an outstanding importance from an equity, social cohesion and integration perspective. The scheme proposed by Health of Canada (6.) gives a good illustration for this:

Direct Effects

People limited in literacy may have difficulty

- Understanding and using health information such as advice on self-care, instructions for medications, food labels, and safety warnings;
- Accessing services which support

Indirect Effects

People limited in literacy are likely to live in poverty, and

- Lack access to a secure food supply;
- Live in low quality housing;
- Work in unsafe environments;
- Experience isolation and social exclusion;

their health;

- Navigating through a complicated health care system;
- Interacting with health care providers.

• Encounter high stress in daily living;

- Have less physical activity, poorer diets, and smoke more;
- Face barriers to fostering healthy development during the early years.

People with low level of health literacy:

- are more likely to use emergency services;
- are more likely to be hospitalised;
- are less likely to be compliant with medicines;
- are less likely to use preventive services;
- incur higher health care costs.

The critical social groups with higher prevalence of low health literacy are:

- the elderly;
- Roma and other ethnic minorities;
- Migrants;
- other socially excluded persons (in situation of deep poverty, unemployment, homelessness) with low general literacy.

It is important to note that health care professionals (doctors, nurses, public health workers) can also have poor health literacy skills.

The Asset Model, described recently by Morgan and Ziglio(17.), provides a synthetic framework for developing policies and programmes to promote health literacy. An inventory of health and development assets include family and friendship networks, intergenerational solidarity, community cohesion, environmental resources necessary for promoting physical, mental and social health, employment, tolerance and harmony, life-long learning, safe and pleasant housing, participation opportunities, social justice and enhancing equity.

There is a need to embrace an assets perspective in relation to health literacy (as distinct from

one that emphasizes deficits and shortcomings), an approach that works with people in a supportive way.

Such an approach calls for a departure from the traditional focus on the 'deficiencies'.

The right to health literacy

Health literacy according to Kickbusch at all.(14.) is a right of citizenship. Health literacy is part of the fundamental skills needed to function in modern society. Political engagement and accountability with designated advocates and the universal right of access to health literacy must be recognised; it is critical to create a voice for health literacy in the political process. Health literacy is a joint responsibility. As expressed in “Navigating Health”: “Health is too important a facet of society to be the sole responsibility of the health care sector.”(14.)

Health is a social achievement, an achievement of every citizen in Europe. The actual conditions in health/health literacy are different in each member state of the Council of Europe. The public authorities of the member states have the responsibility to guarantee the right to health of their citizens. The right to health protection needs to be better defined at European and at country level. This right must be widened and specified as related to health literacy.

An appropriately defined right to health - even considering the actual discussions and doubts - should be incorporated as a basic right, together with the values of human dignity, freedom, equality, and solidarity. Criteria and cooperation instruments should be defined to ensure the right to health/health literacy, to improve cohesion, and to trigger European convergence of legal developments in this field.

Realizing the right to health requires a strong focus on strengthening health literacy. Taking a human rights approach to health means also understanding the underlying social determinants of this right.

In the wording of Kawachi(8.), “Health literacy is a building block to health and is a foundation for modern citizenship. It is a critical component of social capital and should be treated as such in policy debates – not just in health but across all sectors.”

Conclusions

1. Health literacy development from a social cohesion prospective encompasses the study and use of strategies to inform and influence individual and community action that enhance health and democracy of society. Health literacy can contribute to all aspects of disease prevention and health promotion of citizens and is relevant in a number of other contexts, including:

- health professional-patient relations with the different groups of the population;
- navigation in the health system;
- individual exposure to search for, and use of health information;
- the dissemination of individual and population health information, that is health communication.

2. A social cohesion-centred perspective is needed in health literacy development reflecting the realities of different people's everyday lives and their current practices, attitudes, beliefs, and lifestyles. A good health literacy development action has to consider the experience of different citizens with the health care system, attitudes towards different types of health problems, and willingness to use certain types of health services. Particular attention should be paid to the needs of deprived, socially excluded groups of the populations.

3. In aiming for better health literacy and increasing social cohesion, it has to be recognised that:

- Health policy, programmes and practices affect citizen and stakeholders differently as a result of their differing roles, responsibilities and access to resources;
- Inherent structural biases and gaps in communication channels within the health system disadvantage some groups. Health policy, programmes and practices must acknowledge and address these systemic biases to maximise health via health literacy for all groups;
- The impact of health literacy on health occurs within a social context where factors such as age, ethnicity, disability, socioeconomic status, geographical location, or cultural identity influence health status and behaviours.

4. The basic elements of analysis with regards to health literacy are:

- To assess differences according to the determinants of health and ill-health;
- To identify how and where different services are provided, and identify and explain differences in citizens' choices and use of services related to health literacy;
- To consider the type and the way in which information is presented in the planning and delivery of health services;
- To consider how differences in the accessibility and appropriateness of health information are borne in the community;
- To identify and remove barriers to achieving better health literacy.

Recommendations

1. The prerequisite of a successful health literacy development programme is the complexity of planning and implementation, involving all stakeholders, based on a participatory approach.
2. Social status, gender and life-cycle are cornerstones of social cohesion; an effective mix of the most important health determinants is needed to be considered in actions to improve health literacy.
3. Positive changes in health literacy should be well targeted, acting as skills elevators, with appropriate supportive measures and services.
4. Flexible local actions involving the community and all the relevant stakeholders focusing on literacy, equity and health may have real practical impact and fair chances for a small-scale but important success.
5. Directing primary care (including nursing) and public health systems to focus on health literacy, as a complement to the traditional approach of addressing individual and community health problems, may contribute to better health of the population. Health literacy should, therefore, receive greater attention in public health and primary care practice, education, and research.
6. Comprehensive social cohesion-based approaches of tackling social determinants of health with a focus on health literacy may have a broader and more sustainable health impact than the efforts of the health system alone.
7. Individual health literacy development have a multiplication effect on community cohesion; and vice versa, community health assets increase individual health literacy. Therefore, policy needs to consider the complexity of different levels (individual, local, national, European).
8. A consideration of the impact of health literacy as a factor influencing health and social cohesion should inform every stage of health policy, programme and the legislation development process and should include consultation with citizens.

Annex.: CoE Social Cohesion Indicators related to health literacy

Are the conditions in place to ensure that health is fully taken into account in everyone's autonomy and personal development?

Health promotion and information

Coverage of the public health information system

Coverage of prevention campaigns initiated by NGOs

Coverage of awareness campaigns on the distribution and use of prescription drugs

Health education courses

Time spent by doctors in informing patients about their state of health

Accessibility of information given to patients

Free and accessible information on the overall health care system

Use of the Internet to provide the patient with information

Hotline for questions relating to health

Ownership of the medical file

Information on generic drugs

Print run of magazines providing health information

Encouragement for self-care

Availability of drugs for self-medication

Reimbursement rate of drugs for self-medication

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