Health literacy and health inequalities: Summary Overview

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Executive Summary

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The Scottish Government’s National Health Literacy Action Plan (2014) “explains that low health literacy leads to poor health outcomes and widens health inequality”. However, whilst it is generally accepted that individuals with low health literacy have poorer health outcomes and poorer use of health services (Berkham et al 2011 1), the role that health inequalities plays in this relationship remains poorly understood.

The purpose of this current review is to consider the relationships between health literacy and health inequalities. It concluded that:
• Inequalities are caused by a fundamental inequity in the distribution of power, money and resources. This has an impact on the opportunities for good-quality work, education and housing, etc. In turn, these determinants shape individual experiences and health throughout life.

• Health literacy and functional literacy are very closely related and the terms ‘literacy,’ ‘health literacy’ and ‘functional health literacy’ are often used interchangeably in research literature. Functional literacy has been defined as “the ability to read, write and speak in English, and to use mathematics at a level necessary to function at work and in society in general”). In many definitions of health literacy, there is no clear difference between functional literacy and health literacy except that health literacy is associated with the healthcare environment.

• Whilst it is generally accepted that individuals with limited health literacy have poorer health outcomes and poorer use of health services, the relationship between literacy (functional and health literacy) and health inequalities is unclear.

• Health literacy is correlated with age, employment status, social status, financial deprivation and education. Limited health literacy follows a social gradient and can further reinforce existing inequalities. People with limited health literacy most often have lower levels of education, are older adults, are migrants and depend on various forms of public transfer payments.

• Strengthening health literacy can help to address health inequalities because:
  o Health literacy is an asset for individuals and communities.
  o Health literacy is an important form of social capital.
  o Health literacy means empowerment.

1 Introduction

Health literacy is increasingly being recognised as a significant public health concern, but the term health literacy has been a source of considerable confusion and debate (Baker 2006). Health literacy has been defined in many different ways since it was first introduced as a term and concept. The European Health Literacy Consortium for the European Health Literacy Survey developed the following working definition and conceptual model of health literacy:

Health literacy is linked to literacy and entails people’s knowledge, motivation and competences to access, understand, appraise and apply health information in order to make judgements and take decisions in every-day life concerning health care, disease prevention and health promotion to maintain or improve quality of life during the life course.

In May 2014, the Scottish Government published Making it Easy: A Health Literacy Action Plan for Scotland. This focuses on improving the healthcare system and workforce capacity and capability to make it easy for people to access and use information about health and wellbeing, rather than seeing health literacy as a gap that needs to be addressed in patient/service user capabilities. The Action Plan:

• Highlights the hidden problem of low health literacy and the impact that this has on our ability to access, understand, engage and participate in our health and social care.

• Calls for all of us involved in health and social care to systematically address health literacy as a priority in our efforts to improve health and reduce health inequalities.
Sets out an ambition for all of us in Scotland to have the confidence, knowledge, understanding and skills we need to live well, with any health condition we have.

Lays out the actions the Scottish Government and partners are taking to help all of us in health and social care collaborate and help realise this ambition.

The National Action Plan also “explains that low health literacy leads to poor health outcomes and widens health inequality”. However, whilst it is generally accepted that individuals with low health literacy have poorer health outcomes and poorer use of health services (Berkham et al 2011), the role that health inequalities plays in this relationship remains poorly understood. The purpose of this current review is to consider the relationships between health literacy and health inequalities.

2 What are health inequalities, and why do they exist?

Health inequalities are avoidable inequalities in health between groups of people. Health inequalities are the ‘systematic differences in the health of people occupying unequal positions in society’ (Graham, 2009). They are most commonly associated with socio-economic inequalities but can also result from discrimination. Health inequalities in Scotland are wide and increasing. An Audit Scotland report, Health inequalities in Scotland (2012) says that while overall health has improved in the past 50 years, deep-seated inequalities remain. The social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics. Deprivation is the key determinant, although age, gender and ethnicity are also factors.

NHS Health Scotland recent policy review of health inequalities (2013) concluded that:

“Inequalities are caused by a fundamental inequity in the distribution of power, money and resources. This has an impact on the opportunities for good-quality work, education and housing, etc. In turn, these determinants shape individual experiences and health throughout life”. (p1)

The key messages from the review include:

- Average life expectancy in Scotland has improved steadily, but more slowly than in other wealthy countries. Within Scotland, those at the top of the social scale have been able to take health improvement messages on board which has resulted in health benefits for them. However, less affluent groups have benefited less and have been left behind. Inequalities in mortality in Scotland are among the highest in Western and Central Europe, rising rapidly during the 1980s and 1990s; this situation is not inevitable and can be improved.

- The scale of the health inequalities problem is strongly influenced by the magnitude of the underlying inequalities in power, money and resources within a society. Action on the worsening trends in health inequalities needs to be rebalanced to address the fundamental drivers of social inequality which determine income, employment, education and daily living conditions.

- The ways in which health inequalities are manifested in the population, through specific diseases and causes of death, are likely to change over time; strategies focused on specific diseases and
single risk factors are important but will not substantially impact on the overall inequalities in death rates.

2.1 Financial income, employment and wealth

Various longitudinal studies have established a relationship between greater income/wealth and better health (Commission on Social Determinants of Health 2008\(^\text{10}\); Davey-Smith et al 1998\(^\text{11}\)). Despite this strong relationship, it does not follow that those societies with the greatest wealth have the best health outcomes (NHS Health Scotland 2013\(^\text{12}\)). Whilst increasing income within poor countries improves health, a further increase in income within rich countries does not. On this basis it has been suggested that income inequality, rather than average income, better predicts average population health (Wilkinson & Pickett 2009\(^\text{13}\)). There is good evidence on the links between unemployment and health. A recent US-based systematic review summarised that, on average, mortality rates in the unemployed increased by 63% compared to those in continuing employment (Roelfs et al 2011\(^\text{14}\)). Individual income and wealth is also likely to be linked to health outcomes, through factors such as perceived security and personal assets. Being more certain about how things will be paid for in the future, job satisfaction, self-worth, sense of identity, and access to social networks and connectedness to community life may all be mechanisms linking income to health inequalities (Davey-Smith et al 1998\(^\text{15}\); Roelfs et al 2011\(^\text{16}\)).

2.2 Environmental and individual factors

It has been suggested that there are a number of wider environmental factors that influence health inequalities as well, including availability and quality of schools, air and housing quality, safety of neighbourhoods, availability and accessibility of services, and community engagement (NHS Health Scotland 2013\(^\text{17}\); Marmot et al 2010\(^\text{18}\)). In turn, these factors are influenced by individual factors, such as job security and control, fuel poverty, diet, activity levels and tobacco consumption, early cognitive development, literacy and numeracy, qualifications, quality of services received, social supports, and coping and resilience (NHS Health Scotland 2013\(^\text{19}\)).

UK-based researchers have conducted a meta-review (a review of reviews) of psychosocial factors that may relate to health inequalities (Egan et al 2008\(^\text{20}\)). They define ‘psychosocial’ factors as including support from social networks, control at work or in the home, security and autonomy, and work-family conflict. They concluded that positive psychosocial environments go hand in hand with better health, and that poor psychosocial environments may be health damaging and contribute to health inequalities. However, the researchers also point out that the available research evidence is of variable quality and consistency, and that future research should seek to improve this.

Health inequalities do not arise by chance, and they cannot be attributed simply to genetic make-up, ‘bad’ unhealthy behaviour, or difficulties in access to medical care, even though those factors are important. Social and economic differences in health status reflect, and are caused by, social and economic inequalities in society, which are largely beyond the control of individuals and families (Marmot et al 2010\(^\text{21}\); NHS Health Scotland 2013\(^\text{22}\)). The consequences for children who are born and grow up in environments that increase health inequalities become apparent early on, and often
remain over the life course (NHS Health Scotland 2013\textsuperscript{23}). This suggestion is echoed in a recent UK-based systematic review, which concluded that risk of death from all causes is higher amongst those who experience poorer socioeconomic circumstances during childhood, a pattern which appeared similar for women and men (Galobardes et al 2008\textsuperscript{24}).

2.3 The Glasgow effect

Inequalities in health are clearly apparent in Scotland. In 2009/10, for example, life expectancy at birth for men was 69 years for the most deprived 10th of the population compared to 82 years for the least deprived 10th, a difference of 13 years. The difference in healthy life expectancy was even greater, at 47 years for men in the most deprived 10th compared to 70 years for those in the least deprived 10th, a difference of 23 years (NHS Health Scotland 2013\textsuperscript{25}). The Glasgow effect refers to the unexplained poor health and low life expectancy of Glaswegians compared to the rest of the United Kingdom and Europe. It has been suggested that poverty alone does not explain these stark health inequalities, as equally deprived former industrial cities of the UK such as Birmingham, Liverpool and Manchester that have faced similar effects of de-industrialisation have higher life expectancies, and the wealthiest ten percent of the Glasgow population have a lower life expectancy than the same group in other cities (Walsh et al 2010\textsuperscript{26}). Various suggestions have been proposed to account for the effect, which appears to have widened since the 1970s, including vitamin D deficiency, cold winters, higher levels of poverty than the figures suggest, high levels of stress, and a culture of alienation (Reid 2008\textsuperscript{27}).

3 Functional literacy and health literacy

Health literacy and functional literacy are very closely related (Public Health Wales 2010\textsuperscript{28}), and the terms ‘literacy,’ ‘health literacy’ and ‘functional health literacy’ are often used interchangeably in research literature. Functional literacy has been defined as “the ability to read, write and speak in English, and to use mathematics at a level necessary to function at work and in society in general” (Easton et al 2010\textsuperscript{29}). In many definitions of health literacy, there is no clear difference between functional literacy and health literacy except that health literacy is associated with the healthcare environment (Easton 2011\textsuperscript{30}).

Most research that examines the relationship between functional literacy and health literacy involves people who have cognitive difficulties or who do not speak the dominant language of their society. However, there are many other people that can talk readily about health and other issues but have problems using written information. A recent Scottish systematic review has suggested that there is evidence of this ‘hidden population’, whose functional or health literacy problems have different implications because they are less likely to be recognised and addressed (Easton et al 2010\textsuperscript{31}).

A recent UK-based systematic review (Easton et al 2010\textsuperscript{32}) concluded there is some evidence that lower functional or health literacy is associated with poorer health status, both when assessed by self-report and when measured objectively. It also found no evidence of a clear relationship between functional literacy, or health literacy, and preventive health or health risk behaviours. In
relation to health service use, people with higher and lower levels of literacy had similar levels of access to services, but people with lower literacy had less appropriate patterns of use and weren’t always able to secure appropriate treatment. UK and US-based systematic reviews (Easton et al 201033; Berkham et al 201134) have also concluded that individuals with limited health literacy have poorer adherence to medicine, and higher hospitalisation rates. Berkham et al 201135 also concluded that poor health literacy is related to greater use of emergency care, lower mammography screening rates, flu vaccine uptake, poorer ability to interpret labels and health messages, and, among elderly people, poorer overall health status and mortality rates. Collectively, these findings suggest that people with poorer health literacy skills may be less likely to adopt effective health promoting or self-care behaviour. However, there is an ongoing debate about how limited functional literacy affects people’s health in relation to how limited health literacy affects people’s health (WHO 201336); and although the European Health Literacy Survey (201237) confirms a social gradient for education, by showing that health literacy is significantly higher among people with more education in all participating countries, this differs somewhat between countries.

Capacity and competence related to health literacy vary according to context, culture and setting. They depend on individual and system factors. These factors include communication skills, knowledge of health topics, culture and the specific characteristics of the health care, public health and other relevant systems and settings where people obtain and use health information. When these services or systems, for example, require knowledge or a language level that is too high for the user, health suffers.

4 Health literacy and social inequalities

People are not defined by any singular characteristic. Social determinants such as ethnicity, gender, disability, and sexual orientation combine and intersect to affect health and wellbeing, often varying across the life-course. The UK Equality Act 201038 provides protection from discrimination in relation to protected characteristics; and whilst the research on health literacy does not cover all of these characteristics, our review covered health literacy in relation to age, disability, and race and ethnicity.

4.1.1 Older people

A recent US-based systematic review (Zamora & Clingerman 201139) indicated that low levels of health literacy are more common among adults aged 65 and older than for any other adult age group. The review indicated that older adults and their caregivers need reliable health information to help prevent and manage disease, promote their health and follow public health recommendations and warnings. However, differences in access to formal education and literacy training, the complexity and technical nature of health information, and the natural processes of aging may compromise older adults' capacity to use health information and make sense of messages. Furthermore, Gellard et al (201140) found that limited health literacy may be a barrier to adults aged 65 and older obtaining and adhering to medicines. They concluded that health care staff need to better understand how cognitive functioning, and changes in vision and hearing, impact on health literacy levels in older adults.
4.1.2 Children and young people

US-based systematic reviews have suggested that low parental/caregiver literacy is related to poorer child health outcomes (DeWalt & Hink (2009); Saunders et al 2009). Adults with limited literacy skills are more likely to make errors in dosing child medication (Saunders et al 2009). Negative health outcomes for children with asthma and type 1 diabetes have been related with caregivers with limited functional literacy skills, but these relationships are not consistent across studies. The strongest relationships between health literacy and child health outcomes are in care of newborn infants and care of children with special health care needs (Saunders et al 2009): for families with limited health literacy skills, complex health information can make it much more difficult to access child health care; increase threats to child safety; and challenge effective management of special health care needs. Better definitions and measures of health literacy in child health are required, along with additional research and more joined up working between health, social care and education professionals in order to address these problems in the future (Saunders et al 2009; Ormshaw et al 2013).

4.1.3 People with long-term medical conditions

Health literacy plays a crucial role in enabling people to manage chronic diseases such as diabetes and heart disease themselves. People with limited health literacy have more difficulty in managing long-term conditions on a daily basis, including making lifestyle changes, making informed decisions, and knowing when and how to access health care services (WHO 2013). Health literacy is also an important factor in preventing long-term diseases, as it is associated with health behaviours such as lack of physical activity, poor dietary habits, smoking and alcohol use (WHO 2013, and lower cancer screening rates (Oldach & Katz 2014)). UK and US-based reviews have found that lower levels of health literacy are common among people with chronic kidney disease (Fraser et al 2013), diabetes (Al Sayah et al 2013; Loke et al 2012; Wang & Salter 2012), chronic musculoskeletal conditions (Loke et al 2012; Lowe et al 2012) and heart disease (Baker et al 2011).

4.1.4 People with mental health problems

The relationship between health literacy and long-term physical conditions has received more attention in the literature than the relationship between health literacy and mental health, also known as mental health literacy (MHL) (Jorm 2012). A mental health literacy (MHL) programme has recently been evaluated (Friedli et al 2012) in Scotland as part of wider Dundee ‘Equally Well’ test site activities. The evaluation found that the programme was successful in building upon and extending the mental health improvement role of local organisations, building the capacity of workers to address mental health issues in their day to day roles, and in creating more organisations able to deliver mental health awareness training. However, there was limited success in attracting the local community to take part. For those who did participate, sessions were well received and effective in increasing knowledge and understanding of MHL. The evaluators concluded that further work is needed to identify how best to promote MHL with local communities, taking into account the challenges of overcoming the stigma surrounding mental health issues, which may have contributed to reduced participation.
4.1.5 People with learning disabilities

People with learning disabilities have been highlighted by a number of studies as an at risk group for limited health literacy (Public Health Wales 201059). Limited communication skills may reduce their capacity to convey identified health needs effectively to others. As a result, carers play an important role in the identification of health needs for many people with more severe learning disabilities. However, they may have difficulty in recognising expressions of need, particularly if the person concerned has difficulties in oral communication (Emerson & Baines 201060). A range of organisational barriers to accessing healthcare services have been identified for people with learning disabilities, including failure of health professionals to make ‘reasonable adjustments’ in light of the literacy and communication difficulties experienced by many people with learning disabilities (Emerson & Baines 201061).

4.1.6 People in minority ethnic groups

US-based systematic reviews have concluded that people in ethnic minority groups often have limited health literacy, because they can have difficulties in obtaining, understanding and implementing health information, and therefore have a higher risk of poorer health outcomes (Berkman et al 201162). It has been suggested that African Americans in the US have more limited health literacy than their Caucasian counterparts (Weekes 201263), but there have been relatively few systematic reviews examining the relationships between health literacy and health outcomes in other minority ethnic communities.

Current UK legislation64 requires all public bodies to offer equal services and opportunities to all members of society and to promote race equality. To meet these requirements all public bodies need to promote equal access to health care services and provide accessible health information in various formats and languages. However, ethnic minority groups, asylum seekers and refugees are less likely to visit their GP and seek treatment, and this is often due to a lack of understanding of the health system and/or lack of information about available services. Studies have also highlighted practitioners’ poor understanding of cultural issues due to a gap in the current medical training, which impacts on the assessment and treatment of patients from minority groups (Public Health Wales 201065).

5 A social gradient?

Health inequalities are often observed along a social gradient. This means that the more favourable your social circumstances such as income or education, the better your chance of enjoying good health and a longer life. While there is a significant gap between the wealthy and the poor, the relationship between social circumstances in health is in fact a graded one.

Whilst it is generally accepted that individuals with limited health literacy have poorer health outcomes and poorer use of health services (Berkham et al 201166), the relationship between literacy (functional and health literacy) and health inequalities is unclear. This overview was unable to locate systematic review-level data fitting the search criteria that examines the relationships.
between health literacy and health inequalities. Other researchers have had similar experiences, with (Bambra et al (2010) concluding that there are too few systematic reviews conducted in this area. It is also a challenge to locate relevant systematic reviews, as the terminology used to describe health inequalities and health literacy varies greatly from one study to the next (Bambra et al 2010).

The recent European Health Literacy Survey (2012) developed a conceptual model of health literacy seeks to capture the complexity of the concept by developing 12 sub dimensions of health literacy related to competencies of accessing, understanding, appraising and applying health-related information within health care, disease prevention and health promotion settings (see table 1). This model and definition, which integrates medical and public health views of health literacy, was developed through a systematic literature review and content analysis of 17 peer-reviewed definitions and 12 conceptual frameworks found in extensive literature reviews.

Table 1: The European Healthy Literacy Survey: the 12 sub dimensions as defined by the conceptual model

<table>
<thead>
<tr>
<th>Health literacy</th>
<th>Access or obtain information relevant to health</th>
<th>Understand information relevant to health</th>
<th>Appraise, judge of evaluate information relevant to health</th>
<th>Apply or use information relevant to health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care</td>
<td>Ability to access information on medical or clinical issues</td>
<td>Ability to understand medical information and derive meaning</td>
<td>Ability to interpret and evaluate medical information</td>
<td>Ability to make informed decisions on medical issues</td>
</tr>
<tr>
<td>Disease prevention</td>
<td>Ability to access information on risk factors</td>
<td>Ability to understand information on risk factors and derive meaning</td>
<td>Ability to interpret and evaluation information on risk factors</td>
<td>Ability to judge the relevance of the information on the risk factors</td>
</tr>
<tr>
<td>Health promotion</td>
<td>Ability to update oneself on health issues</td>
<td>Ability to understand health related information and derive meaning</td>
<td>Ability to interpret and evaluate information on health related issues</td>
<td>Ability to form a reflected opinion on health issues</td>
</tr>
</tbody>
</table>


The European Health Literacy Survey (2012) found that health literacy is correlated with age, employment status, social status, financial deprivation and education. Limited health literacy follows a social gradient and can further reinforce existing inequalities. People with limited health literacy most often have lower levels of education, are older adults, are migrants and depend on various forms of public transfer payments.

The European Health Literacy Survey (2012) also identified vulnerable groups particularly at risk of limited health literacy:
- 80% of those with no or very little education
- More than 75% of persons with very bad health status
- More than 70% of those who consider themselves as having a low social status
- 60% of persons older than 75
- More than 50% of unemployed or retired people

Income and perceived social class were the only two variables which positively predicted health literacy, and these variables have also been linked to health inequalities (Marmot et al 2010).

A recent Japanese study (Furuya et al 2013) looked specifically at health status, socioeconomic status and self-rated health in a total of 1237 participants. This study found that good self-reported health was related to younger age, employment, and higher health literacy scores. Respondents with lower education were more likely to have poorer health literacy. The study suggests that to reduce health inequalities, policy interventions should focus on the promotion of health literacy among deprived socio-demographic groups.

A recent Irish study (Coughlan et al 2013) looked at whether Irish health policy makers should view health literacy as a public health or health inequalities issue. This was done by analysing national survey data and looking at the characteristics of respondents in relation to responses to questions about strategies to improve their general health. The researchers found that participants’ motivation for a health-literate health care system came from across the socioeconomic gradient. This analysis suggested that health literacy in Ireland should be viewed predominately as a public health issue rather than a health inequalities issue.

Additional recent Irish (Doyle et al 2012) and Welsh (Public Health Wales 2011) reports have suggested that although health literacy is undoubtedly related to markers of social gradient such as income and education, a direct, linear relationship cannot be assumed, because those with higher incomes and more education are still at risk of limited health literacy. They may, for example, be unable to evaluate competently the vast and sometimes conflicting information needed to manage or improve their health status.

It has been suggested that the health literacy agenda should be focused on ‘improving health and reducing inequities by empowering both individuals and communities to make informed and ethical decisions about their health’ (Peerson & Saunders 2009; Pleasant & Kuruvilla 2008).

A UK-based strategic review is currently assessing the role of community-based peer support in improving health literacy levels and reducing health inequalities. Initial findings suggest that the role of health inequalities has to be prioritised in policy and funding, and community challenges and needs must be acknowledged (Harris 2013). This review is due to be published in 2015. A second UK-based review (Netto et al 2008) of health promotion interventions involving Pakistanis, Chinese and Indian communities related to cardiovascular disease and cancer prevention and modifiable risk factors has suggested that community involvement in the design and delivery of interventions plays a crucial role in overcoming language barriers, thus ensuring effective communication of health promotion messages. What remains unclear though is the extent to which involvement from representatives of the target community added value to the effectiveness of the intervention due to other factors, for example, due to greater understanding of the norms, values and lifestyles of that community.
The recent WHO (2013) report on health literacy argues strongly that strengthening health literacy helps to address health inequalities:

The people who struggle most with limited health literacy are most often older people, members of ethnic minorities, recent immigrants, people with lower levels of education and/or low proficiency in the national language and those who depend on public transfer payments. The implications for these more vulnerable groups are that limited health literacy often correlates with a lack of ability to effectively self-manage health, access health services, understand available and relevant information and make informed health-related decisions. Targeted initiatives can strengthen health literacy among vulnerable groups and can help to address gaps in health inequality. Measures to strengthen health literacy among children are key. (p15)


1. **Health literacy is an asset for individuals and communities.** Investment in strengthening health literacy is likely to yield a substantial return in health and well-being at both the individual and community levels. People acquire and use personal health literacy based on the social environments in which they live, and social action can improve these environments. Combined with appropriate social resources, health literacy can become an asset that will sup-port people in becoming more resilient (have a sense of adaptation, recovery and bouncing back despite adversity or change) and active for health: for example, by adopting healthier lifestyles or demanding their rights as patients as well as taking action to improve health in the community and contribute to sustainable development.

2. **Health literacy is an important form of social capital.** Communities benefit from the health literacy of their members, and community members benefit from community sup-port and resources – such as self-help groups and neighbourhood support – in enhancing their health literacy. Such characteristics make health literacy a part of people’s cultural capital. Cultural capital is linked to health outcomes and people’s opportunities to be active for their health. Possessing and applying cultural capital – in the form of knowledge, values, norms and skills – increases peoples’ potential to pursue healthy lifestyles and is positively associated with peoples’ health.

3. **Health literacy means empowerment.** Health literacy is rooted in the health promotion movement, with the aim to empower people as citizens, members of the workforce, consumers and patients so that they can better make decisions about their health and improve their skills in managing themselves. Empowerment is both a process through which people gain more control over their lives, their health and its determinants and an outcome that reflects the ability of people – individuals or communities – to influence the world. Through empowerment, health literacy programmes contribute to democratising the health care system and to achieving a stronger commitment to health and well-being in communities and in society at large.
6 Conclusions

- Inequalities are caused by a fundamental inequity in the distribution of power, money and resources. This has an impact on the opportunities for good-quality work, education and housing, etc. In turn, these determinants shape individual experiences and health throughout life.

- Health literacy and functional literacy are very closely related and the terms ‘literacy,’ ‘health literacy’ and ‘functional health literacy’ are often used interchangeably in research literature. Functional literacy has been defined as “the ability to read, write and speak in English, and to use mathematics at a level necessary to function at work and in society in general”). In many definitions of health literacy, there is no clear difference between functional literacy and health literacy except that health literacy is associated with the healthcare environment.

- Whilst it is generally accepted that individuals with limited health literacy have poorer health outcomes and poorer use of health services, the relationship between literacy (functional and health literacy) and health inequalities is unclear.

- Health literacy is correlated with age, employment status, social status, financial deprivation and education. Limited health literacy follows a social gradient and can further reinforce existing inequalities. People with limited health literacy most often have lower levels of education, are older adults, are migrants and depend on various forms of public transfer payments.

- Strengthening health literacy can help to address health inequalities because:
  - Health literacy is an asset for individuals and communities.
  - Health literacy is an important form of social capital.
  - Health literacy means empowerment.

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