

Does active participation in health enhance health outcomes and health care delivery systems?

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Abstract

In 2000 a Committee of the United Nations Economic and Social Council recognised health as essential for exercising all other rights (Djité 2008). The World Health Organization (1998) also sees health as a vital resource for enabling citizens to lead individually, socially and economically productive lives. However health is one space where the opportunities to participate and exercise voice is directed by the provision of health resources and material. Now in late modernity health has become a goal for citizens to work towards or they risk suffering from chronic illness and premature death (Cockerham 2005). The procurement of health has also shifted from the state as the provider of equitable health care to all citizens to a commodity that can be purchased in an expanding health market place (Kickbusch 2004). If health has become the responsibility of the citizen, issues of health literacy, multimodal access to information and multilingualism need to be considered. This research report focuses on work produced as part of the first author's doctoral project, exploring the phenomenon of consumption of health resources for health citizenship in the private health insurance industry. Based on data collected from 75 participants through an electronic questionnaire, as well as different genres of information utilised for health promotion, the project investigated how the construction of information and the multimodal tools used by two leading South African health insurers influenced the consumers' health subjectivity. Data collected showed the importance of multilingual information, health literacy and multimodal tools for enabling participation and voice among consumers. In addition, the consumers proposed more accessible information and better designed newsletters and web sites to help them with information seeking for health knowledge and health citizenship.

Keywords: Health citizenship, health communication, consumers, health literacy, private health care

1. Introduction

The South African public health care sector has experienced major transformations, particularly with the refurbishment of old and construction of new health care facilities. These achievements are coupled with free access to health care provided to pregnant women, children and people living with disabilities (Yach and Kistnasamy 2007). However these successes are tarnished by the country's poor health performance, which in comparison to other middle income and, in some cases, lower income countries, ranks very low (Yach and Kistnasamy 2007). This poor health showing is worsened by an unequal health care system where the private sector, which provides health care to less than 20% of the population, consumes more than 60% of the health care budget (Yach and Kistnasamy 2007). Clearly the private health care industry is well resourced and entrenched, meaning that to find examples of best practice in how health resources can be used to encourage consumer participation and construct a health citizenry, this would be the sector that may have the answers. This paper therefore examines how two leading health insurers – health insurer 1 and health insurer 2 – utilise different genres of textual information to promote health. The lessons learnt and examples from this industry can help in devising replicable and appropriate interventions to improve the public health care sector.

Health insurer 1 is the largest health insurer in the health market with over 2.4 million beneficiaries, while health insurer 2 is restricted to only Government employees and has more than 1.5 million beneficiaries, covering 3% of the South African population¹. These health insurers are large organisations that continuously shape the health care landscape by interacting with and reaching millions of citizens on a regular basis.

The health care system, for both insured and uninsured populations, in the public and private health care sectors, can be difficult to navigate. In a multilingual country such as South Africa, providing health information to the general population can be complex, “where only languages of limited diffusion are spoken” (Kruger 2008). Kruger (2008:152) explains that in South Africa, all eleven languages are minority languages as no language completely dominates all other languages. The health insurers therefore have a complex role in the construction of appropriate health messaging, which has to be tailor-made for a multilingual target group. The health insurers are essentially involved in what is called health communication, which is concerned with resolving health care issues.

This study is a linguistic inquiry of health communication, which is an applied behavioural science that looks at human and mediated communication in the health care system. The focus is on finding problems, analysing them and devising solutions for these problems (Kreps Bonaguru and Query 1998). In the field of health care, communication is regarded as the process where information is distributed for health care delivery and to promote public health (Kreps et al., 1998). To promote health, information is distributed to a broad target audience. For example, health insurer 1 attracts the high end of the market, in contrast to health insurer 2, which aims to extend health care cover to those government employees who have none. This means that there are different spaces for participation and in which to express voice by different consumers. However, Gaventa (2002) cautions that the existence of these spaces does not mean that different groups can use them equally, as these are socially and politically located and will allow for differing levels of citizen engagement.

¹ Anyone can register with an open health insurance organisation, while restricted or closed health insurance companies cater for a specific group of people.

1.1 Research questions

This research report concentrates on data collected in an investigation of how two specific health insurers communicate using different languages and a number of multimodal resources (such as web sites, brochures, newsletters, member guides and application forms) to provide health information to their clients. The specific aims of the research are to investigate:

- how different languages are used to foster participation and voice in the health insurance industry;
- how health information for health promotion is constructed across various artefacts;
- how consumers interpret and internalise this health information;
- how consumers navigate the health landscape, participate and express their voice in the provision of health care across multilingual contexts; and
- how health insurers construct health citizenship and what their contributions are to national and international markets.

2. Theoretical framework

The concept of “health citizenship” can be traced to 1792 and the French revolutionaries who believed that health should form part of the social contract between the state and its citizens (Porter 2011). This contract also meant that it became the responsibility of the citizen to maintain a healthy lifestyle relating to “the consumption of pleasure and the exercise of passions” (Porter 2011:1). It has become evident that the design and health of one’s body is dependent on following a healthy lifestyle (Cockerham 2005). Health citizenship has emerged as an integral part of modernity, where health has turned into something citizens can do and buy.

The obsession with keeping the ideal body has seen the rise of elective surgery, those medical procedures that are unnecessary and performed due to vanity (Gilman 1999). Surgery for beauty has become a worldwide phenomenon where tourists, for example, visit Marbella in Spain for face lifts, or receive breast reductions and penis enlargements in South Africa as part of their trip to visit the Kruger National Park (Gilman 1999). Surgery is probably one of the most overt symbols of a modern society fascinated by health, beauty and sexual attractiveness.

The new health society has not only seen health being epitomised, it has also created a space where notions of citizenship have been challenged and reshaped. Citizenship has been largely viewed from the perspective of nationality and the rights and responsibilities given to people belonging to a state (Gaventa 2002). However, people can have multiple citizenships and various linguistic repertoires. Citizenship has become an arena of struggle of domination and resistance, where scholars are researching other concept of what it means to be a citizen. This is shown in the increase of various forms of citizenship studies focused on for example queer politics, aboriginal studies, and environmental studies (Isin and Turner 2002).

In the health context, citizens have to participate in the decisions that affect their health, however issues of language and literacy need to be considered. Health literacy, which refers to the ability to obtain, process and understand health information, is an important part of health communication and health promotion.

Significant in this study is the consideration of language and literacy in health communication for active participation in health. According to Blommaert (2007) different languages have

different indexical values and are located according to differential scale levels. Kickbusch (2001:294) mentions that it is important to focus on power in the health literacy debate, as literacy is also distributed across different scale levels. Wright (1998) sees different languages as having varying levels of significance across multilingual contexts. He says the significance of English depends on wealth and power in the large-scale global economy, while African languages have less significance in this context as they are utilised at a smaller social scale of communication largely linked to cultural heritage. This is further explained by Prinsloo (1999:418) who says “[...] in a multi-lingual society where some languages are associated with status and power, literacy issues are always inseparable from language as well as from larger socio-political issues to do with the access to and the policing of social resources.”

Investigating the languages which consumers can access these health resources for their health is essential for an analysis of health communication across multilingual contexts. Stroud (2000, 2001) notes that even though linguistic rights have been identified as solutions for citizen involvement among minority groups, these concepts exclude the very minorities they were meant to protect. The alternative is linguistic citizenship which includes various linguistic practices and resources utilised by civil society (Stroud 2000, 2001). Linguistic citizenship is defined as “the situation where speakers themselves exercise control over their language, deciding what languages are, what they mean and where language issues are discursively tied to a range of social issues, policy issues and questions of equity” (Stroud 2001:353).

2.1 Health literacy as a pathway towards health citizenship

Health literacy is important for giving voice to consumers and allowing them to participate in health issues. Kanj and Mitic (2009:4) view health literacy as an empowerment tool for promoting active citizenship. They maintain that health literacy is achieved when individuals understand their rights as patients, including being able to navigate the healthcare system, and by actively participating as informed members (Kanj and Mitic 2009). Health literacy is required for participation in the health care system and for people to understand their treatment options and decisions. Participation and voice in health are important as they are the route towards encouraging health citizenship by empowering consumers to become involved in knowing their health risks and improving their health.

Gaventa (2002:3) notes that a great deal of literature has described participation from the perspective of citizenship. Participation is fundamental to active citizenship as it emphasises the “agency of citizens as ‘makers and shapers’ rather than as ‘users and choosers’ of interventions or services designed by others” (Gaventa 2002:4). In the words of Ferguson (1999:7) people have to exercise their democratic rights to participation in the decision making process for the provision of health services (Gaventa 2002).

Participation is tied down to voice, addressing inequalities means giving voice to allow for democratic participation. Citizen engagement in spaces of participation offers the opportunity to express voice (Gaventa 2002). Even so, Gaventa (2002) says the existence of these spaces does not mean that different groups can use them equally, as these are socially and politically located and allow for differing levels of citizen engagement. Hanafi (2009:12-13) citing Bamgbose (1991:47), argues that to encourage democratic participation, accountability and mass participation, attention has to be paid to the problem of how best to use multilingual resources.

3. Research design and data analysis

Data were collected by distributing an electronic questionnaire that consists of multiple-choice questions. Designed and hosted on a website, the questionnaire was sent to participants via a mass email containing a link to the questionnaire. An electronic questionnaire is a valid research tool that is less intricate and time-consuming than a print survey (Bethlehem and Hundepool 2000:133).

Data collection also involved gathering over a period of six months of different textual genres such as newsletters, brochures, annual reports, application forms and website information. This content was audited to understand how the health insurers communicate with their consumers.

As a research instrument, the questionnaire solicited information relating to the participants' language preferences for receiving health information, their use of multimodal artefacts, and the effectiveness of these artefacts as tools to use regarding their health concerns, while looking at possible areas of improvement.

In total, 75 participants completed the questionnaire: 22 from health insurer 1, 29 from health insurer 2 and 24 from other health insurers. It was not the point of the research to gather data from other health insurers, however based on the relevance of the data and the valuable feedback received, the data were used in the analysis. The results were as follows:

- In terms of home language, 36% of participants selected English, 32% selected Afrikaans, 13% selected Setswana, 12% Sepedi, 10.6% isiXhosa, 6.5% isiZulu, and 2.6% indicated that they spoke isiNdebele, Siswati, and/or Venda as a home language.
- While 86% of the 75 participants indicated that they would prefer to receive information in English, approximately 93% of the participants indicated that the information they received was in English. This shows a preference by the health insurers to disseminate information mainly in English.
- Most of the participants (72%) found the information they received from the health insurers useful, while 25% were not certain if the information were useful or not.

Noteworthy comments relating to the language in which the participants received information included:

Sometimes the jargon used is not always easy to understand. [Health insurer 2] send statements and sms's regularly, but, I do not even understand it especially the statements.

(Participant 46 from health insurer 2)

Each source is **addressing a slightly different population** thus a combination of how things are explained gives a comprehensive picture. All specialised topics tend to have **a specific vocabulary which is linked to the function** - Medical aids also have catch phrases and descriptions which need to be **translated into basic English for full understanding.**

(Participant 27 from health insurer 2)

The health insurers need to consider the multilingual distribution of health information while taking into account the different health literacies by the consumers and the challenges of

complex medical jargon contained in the information they communicate. Across the data it was evident that participants generally perceived health insurers as enablers for them to participate in issues around their health concerns. However, easy to read newsletters and better designed websites (according to 65% of participants) were highlighted as tools that could make it easier for the participants to navigate through health information.

4. Conclusion

The research outlined in this report has shown the importance of health information and the construction of the information across multimodal health tools, for encouraging participation and voice among consumers. Linguistic, textual, multimodal features and health literacy have been identified as a challenge in the dissemination of health information, and the consumers have proposed more accessible health information and better designed artefacts for their health subjectivity. Health information has to be accessible and empower citizens to improve their health knowledge, health outcomes, and enhance health care delivery systems.

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