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BRIDGING THE GAP: THE IMPACT OF LIMITED LANGUAGE PROFICIENCY ON HEALTH LITERACY AND HEALTHCARE EQUITY

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ABSTRACT: Health literacy has emerged as a critical determinant of population health outcomes, influencing individuals' ability to access, interpret, evaluate, and apply health information in decision-making. Despite its importance, limited language proficiency continues to constitute a major structural barrier to health literacy, particularly within multilingual and multicultural health systems in low- and middle-income countries. This narrative review critically examines the relationship between limited language proficiency and health literacy, with particular attention to its implications for healthcare equity. Drawing on global and African scholarship, the paper synthesizes evidence on how linguistic barriers shape patient-provider communication, influence comprehension of health information, affect treatment adherence, and contribute to disparities in health outcomes. The review further interrogates the structural and systemic dimensions of language-related inequities within healthcare systems. It concludes that addressing these challenges requires integrated policy reforms, strengthened interpreter services, culturally responsive healthcare communication, and digital health innovations designed for linguistic inclusivity.

Keywords: Health Literacy; Language Proficiency; Healthcare Communication; Health Equity; Health Disparities; Multilingual Health Systems

INTRODUCTION

Health literacy is increasingly recognized as a foundational pillar of effective healthcare systems and population health improvement strategies. It extends beyond basic reading ability to include cognitive and social competencies that enable individuals to obtain, process, understand, and apply health information in ways that promote well-being and informed decision-making (Nutbeam, 2017). In contemporary health systems, however, disparities in health literacy remain widespread, particularly among populations with limited proficiency in the dominant language of healthcare delivery.

In multilingual societies such as Nigeria, where linguistic diversity is both extensive and complex, language becomes a critical determinant of health system accessibility and effectiveness. Patients who are not proficient in English, the official language of medical communication, often experience significant barriers when interacting with healthcare providers. These barriers manifest in miscommunication, misunderstanding of clinical instructions, and limited participation in healthcare decision-making processes.

The implications of these communication gaps are profound. They contribute not only to individual-level health risks but also to broader systemic inefficiencies, including increased hospital readmissions, delayed treatment, and poor disease management outcomes. Consequently, limited language proficiency must be understood not merely as a linguistic limitation but as a structural determinant of health inequity embedded within healthcare systems.

Conceptual and Theoretical Framework

This review is anchored in Nutbeam's Health Literacy Framework, which conceptualizes health literacy across three progressive dimensions: functional, interactive, and critical literacy.

Functional health literacy refers to the basic ability to read and comprehend health-related information. Interactive health literacy involves more advanced cognitive and communicative skills that enable individuals to engage in meaningful dialogue with healthcare providers. Critical health literacy extends further to include the ability to critically analyze health information and make informed health decisions within broader social and systemic contexts.

Limited language proficiency undermines all three dimensions simultaneously. At the functional level, it restricts basic comprehension of medical instructions. At the interactive level, it impedes effective communication with healthcare providers. At the critical level, it limits patients' capacity to evaluate health information and participate in shared decision-making.

From a broader theoretical perspective, this issue can also be situated within the Social Determinants of Health Framework, which emphasizes that health outcomes are shaped not only by medical care but also by social, economic, and structural conditions. Language, as a social determinant, plays a pivotal role in shaping access to healthcare information and services.

LITERATURE REVIEW

Language has been widely recognised as a central determinant of health communication effectiveness, particularly in multilingual and multicultural societies. Contemporary scholarship consistently shows that limited language proficiency is closely linked to reduced health literacy, poorer patient outcomes, and widening inequalities in healthcare access.

A significant body of global health communication literature emphasises that health literacy is not merely the ability to read medical information but the capacity to obtain, process, and understand health-related messages well enough to make appropriate decisions. In multilingual settings, this capacity is strongly influenced by language proficiency. The World Health Organization (2023) notes that individuals who receive health information in a language they do not fully understand are more likely to misinterpret instructions, delay treatment, or disengage from formal healthcare systems.

In low-resource and linguistically diverse contexts, scholars argue that language barriers function as structural determinants of health inequality. Patients with limited proficiency in dominant or official languages often rely on informal interpretation, which increases the risk of misinformation.

This issue is particularly evident in countries with strong linguistic plurality, where healthcare systems are frequently designed around a single official language despite the multilingual reality of the population.

Research in sociolinguistics further demonstrates that language is deeply tied to power and social inclusion. Fishman's sociolinguistic perspective explains that dominant languages in formal institutions often create unequal access to essential services. In healthcare settings, this imbalance results in patients with limited proficiency experiencing reduced participation in clinical decision-making. Consequently, they are less likely to ask questions, clarify prescriptions, or fully understand diagnoses, which affects treatment outcomes.

Nigerian scholarship also provides important insights into this phenomenon. Bamgbose (2014) argues that language policy in many African states, including Nigeria, tends to favour colonial languages such as English, thereby marginalising speakers of indigenous languages. This linguistic exclusion has direct implications for healthcare delivery, especially in rural communities where English proficiency remains low. Adegbija (2004) similarly observes that communication gaps between healthcare providers and patients often stem from language mismatch rather than lack of medical resources.

Empirical studies in health communication have shown that patients are more likely to trust healthcare systems when information is delivered in their mother tongue. Odebunmi (2018) highlights that indigenous language use in public health campaigns significantly improves comprehension and community participation. This finding aligns with evidence from global health communication suggesting that language-congruent messaging increases compliance with preventive health measures, including vaccination and disease screening.

Furthermore, Communication Accommodation Theory explains that effective interaction occurs when speakers adjust their language to match the linguistic abilities of their audience. In healthcare settings, such adaptation enhances clarity, reduces psychological distance between patients and providers, and builds trust. When health professionals fail to accommodate linguistic differences, patients may feel alienated or misunderstood, which negatively affects healthcare-seeking behaviour.

Recent international reports reinforce the argument that language barriers contribute directly to health inequities. The WHO (2023) reports that populations with limited proficiency in the dominant language of healthcare systems are disproportionately affected by delayed diagnosis, reduced access to preventive care, and lower treatment adherence rates. Similarly, UNESCO (2023) emphasises that inclusive multilingual communication is essential for achieving equitable access to public services, including healthcare.

In sum, the literature consistently demonstrates that limited language proficiency is not merely a communication issue but a critical social determinant of health. It influences health literacy, shapes patient-provider interaction, and ultimately contributes to unequal health outcomes across populations. Addressing this gap requires systematic integration of multilingual communication strategies within healthcare systems to ensure equitable access to health information and services.

DISCUSSION

Language as a Structural Determinant of Health Communication

Limited language proficiency should be understood as a structural determinant of health rather than an individual deficit. Healthcare systems are linguistically structured around dominant languages, often excluding individuals who operate outside these linguistic norms. This exclusion creates systemic communication inequities that affect all stages of care delivery.

In clinical settings, effective diagnosis and treatment rely on precise communication between patients and providers. When patients are unable to articulate symptoms accurately or interpret medical explanations, the diagnostic process becomes compromised. This leads to incomplete clinical assessments and increases the probability of incorrect treatment pathways.

Clinical Consequences and Health System Burden

The clinical consequences of language barriers extend beyond miscommunication. One of the most significant outcomes is poor treatment adherence. Patients who do not fully understand their treatment regimens are less likely to follow prescribed medications or attend follow-up appointments. Over time, this results in disease progression, preventable complications, and increased healthcare utilization.

In chronic disease management, particularly conditions such as diabetes, hypertension, and asthma, continuous self-management is essential. Limited language proficiency undermines this continuity of care by reducing patient comprehension of long-term treatment plans.

Furthermore, healthcare systems experience increased financial and operational burdens as a result of avoidable hospital readmissions and emergency care usage associated with communication failures.

Psychosocial Dimensions: Trust, Agency, and Patient Experience

Beyond clinical outcomes, language barriers significantly affect the psychosocial dimensions of healthcare. Trust is a foundational component of effective patient-provider relationships. When communication is impaired, patients may perceive healthcare providers as unapproachable or unresponsive, leading to diminished trust.

This erosion of trust often results in reduced healthcare-seeking behaviour, delayed presentation of illness, and increased reliance on informal health networks. In extreme cases, patients may completely disengage from formal healthcare systems.

Additionally, limited language proficiency reduces patient agency—the ability to actively participate in healthcare decisions. This undermines the principles of patient-centred care and shared decision-making that are central to modern healthcare systems.

Structural Inequities and Health System Failure

At a systemic level, language barriers reinforce existing inequalities in healthcare access and outcomes. Populations with limited language proficiency are often simultaneously affected by poverty, low educational attainment, and geographic marginalization. These intersecting disadvantages create compounded vulnerability.

Healthcare systems that lack structured interpreter services or multilingual health resources effectively institutionalize exclusion. As Chiweta-Oduah and Buchanan (2025) note, such structural gaps perpetuate linguistic marginalization and widen health disparities in developing health systems.

Importantly, these inequities are not inevitable. Evidence suggests that structured language interventions significantly improve health outcomes, reduce errors, and enhance patient satisfaction. However, the absence of policy enforcement remains a major barrier to implementation.

Recommendations

To address the impact of limited language proficiency on health literacy and healthcare equity, the following integrated strategies are recommended:

1. Institutionalization of professional medical interpreter services across all levels of healthcare delivery
2. Development and dissemination of multilingual health education materials tailored to local linguistic contexts
3. Mandatory cultural and linguistic competence training for healthcare professionals
4. Integration of language access policies into national health systems and regulatory frameworks
5. Expansion of community-based health literacy programs delivered in indigenous languages
6. Adoption of digital health technologies with multilingual support features
7. Strengthening of health communication research in multilingual and low-resource settings

Conclusion

Limited language proficiency remains a critical but under-addressed determinant of health literacy and healthcare equity. Its effects extend across communication processes, clinical outcomes, patient trust, and systemic access to care. Evidence from global and African contexts demonstrates that language barriers significantly contribute to persistent health disparities. Addressing these challenges requires a shift from individual-focused explanations to systemic reforms that prioritize linguistic inclusivity, culturally responsive communication, and equitable health system design. Strengthening language support structures is essential for achieving meaningful progress toward universal health coverage and health equity.

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