



**LANGUAGE, POWER, AND HEALTH LITERACY: A CRITICAL DISCOURSE
ANALYSIS OF HEALTH COMMUNICATION AT COMMUNITY HEALTH CENTERS**

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ABSTRACT

This study examines the role of language in public health practices at Community Health Centers (Puskesmas) in Depok City by integrating sociolinguistic perspectives, Fairclough's Critical Discourse Analysis (CDA), and the concept of health literacy. It aims to investigate how linguistic choices, power relations, and levels of health literacy shape the effectiveness of communication between healthcare professionals and patients. Employing a qualitative descriptive approach with a case study design, data were collected through observations of medical interactions, semi interviews with healthcare providers and patients, and document analysis of health communication materials, including posters, brochures, and official social media content. The findings reveal that the dominance of medical registers and institutional discourse structures reflects asymmetrical power relations that may hinder patient comprehension and participation. However, the use of linguistic accommodation strategies and simplified language significantly enhances patients' health literacy and trust. These findings highlight the importance of a critical linguistic perspective in the development of inclusive and effective public health communication policies.

Keywords: community health center; critical discourse analysis; health communication; health literacy; sociolinguistics

INTRODUCTION

Effective communication constitutes a core component of public health services, functioning as a crucial link between medical knowledge and patient understanding. In primary healthcare settings such as Community Health Centers (Puskesmas), communication extends beyond the transmission of diagnoses and treatments to include the development of trust, the promotion of treatment adherence, and the encouragement of community participation in preventive and promotive health initiatives. Consequently, the quality of health communication directly affects service delivery and public health outcomes.

In multicultural urban contexts such as Depok City, health communication occurs within complex social and linguistic environments. The population is characterized by diverse ethnic backgrounds, educational levels, and socioeconomic statuses, with Indonesian frequently used alongside local languages and informal urban varieties. This linguistic diversity requires healthcare professionals to demonstrate linguistic and cultural sensitivity to ensure that health messages are accurately conveyed and effectively understood. Inappropriate language choices, registers, or interactional styles may result in miscommunication and reduced patient understanding of health conditions and medical instructions.

Language use in healthcare settings is inherently non neutral. It operates as a mechanism through which power relations are constructed and maintained between healthcare professionals, who possess

institutional and epistemic authority, and patients, who occupy comparatively subordinate positions. Through the deployment of medical terminology, institutional discourse structures, and asymmetrical interactional patterns, healthcare professionals may dominate consultations, positioning patients as passive recipients of information. Such power imbalances can influence health related decision making processes, including treatment compliance and patients' willingness to express concerns or seek clarification.

Previous research has demonstrated that limited health literacy among patients is often associated with the use of complex, technical, and decontextualized medical language. Individuals with low levels of health literacy frequently encounter difficulties in understanding medication instructions, disease prevention guidelines, and medical risks. Despite this, much of the existing literature on health communication continues to prioritize medical or psychological dimensions, with comparatively limited attention to language as a socially situated practice embedded in ideology and power.

Against this backdrop, an integrated approach combining sociolinguistics, Critical Discourse Analysis (Fairclough), and health literacy is both relevant and necessary. Sociolinguistics facilitates the examination of language variation and social context in medical interactions, while Critical Discourse Analysis provides analytical tools for uncovering power relations and ideological processes within health discourse. The concept of health literacy is employed to assess how linguistic practices affect patients' comprehension and health related behaviors. This study addresses existing research gaps by critically analyzing health communication practices at Community Health Centers in Depok City, offering insights into primary healthcare communication in urban Indonesia. From a sociolinguistic perspective, language is understood as a form of social practice shaped by speakers, interactional contexts, and social relations. Language variation, register, and speech style index social identities and reflect speakers' positions within institutional and social hierarchies. As noted by Wardhaugh (2006), language choice is never neutral; rather, it is influenced by power relations, social status, and institutional settings.

In health communication, particularly in medical encounters, the use of professional registers and technical terminology by healthcare providers often produces social distance between practitioners and patients. While medical registers may function as markers of professional authority, they can simultaneously impede patient comprehension. When patients fail to understand medical explanations, they are more likely to adopt passive interactional roles and accept information without seeking clarification, thereby limiting their participation in health related decision making. Accordingly, sociolinguistic analysis is essential for understanding how language variation and linguistic accommodation strategies contribute to—or hinder—the effectiveness of health communication.

Critical Discourse Analysis (CDA), as developed by Fairclough, conceptualizes discourse as a form of social practice that is dialectically related to social structures. Fairclough proposes a three dimensional framework of analysis comprising (1) the textual dimension, which focuses on lexical choices, grammatical structures, and cohesion; (2) the discursive practice dimension, which concerns the processes of text production, distribution, and consumption; and (3) the social practice dimension, which addresses broader social contexts, ideology, and power relations.

Within healthcare settings, medical language can be examined as an institutional discourse that reproduces professional authority and legitimizes medical knowledge. Oneway communication patterns, the dominance of closed ended questions, and limited dialogic space illustrate how healthcare institutions position patients as passive subjects within clinical encounters. Fairclough's CDA enables researchers to uncover how linguistic practices in medical interactions not only convey information but also construct, maintain, and normalize power structures in healthcare service delivery.

Health literacy refers to individuals' capacity to access, understand, evaluate, and use health information in order to make informed decisions regarding their health. Nutbeam (2008) conceptualizes health literacy as comprising three levels: functional health literacy, communicative or interactive health literacy, and critical health literacy. Language plays a central role across all levels of health literacy. Clear, simple, and contextually appropriate language facilitates patients' comprehension of medical information, whereas overly technical and abstract language increases the risk of misunderstanding. In the context of Community Health Centers (Puskesmas), efforts to improve public health literacy are closely linked to healthcare professionals' ability to adapt their linguistic practices to patients' diverse social and linguistic backgrounds. A growing body of international research demonstrates that linguistic barriers in healthcare are associated with lower treatment adherence, increased risks of medical errors, and unequal access to health services. Schillinger et al. (2002), for instance, found that patients with limited health literacy were more vulnerable to miscommunication with healthcare providers, leading to poorer health outcomes.

In Indonesia, studies on health communication have largely focused on health promotion strategies or patient behavior, while research that critically examines language as the primary object of analysis remains limited. Moreover, integrative studies combining sociolinguistics, Critical Discourse Analysis, and health literacy within the context of primary healthcare services such as Puskesmas are still scarce. Accordingly, this study offers both theoretical and empirical contributions to the interdisciplinary field of language and public health, particularly within urban settings such as Depok City.

METHOD

This study adopts a qualitative descriptive approach with a case study design. This approach is appropriate given the research objective of achieving an in depth understanding of health communication practices as sociolinguistic phenomena within the natural setting of primary healthcare services. The case study design allows for a contextualized examination of how language is used, interpreted, and enacted in everyday interactions at Community Health Centers. The research was conducted at several Community Health Centers (Puskesmas) in Depok City that represent the characteristics of a multicultural urban area. Site selection was based on the diversity of patients' social, educational, and linguistic backgrounds. The study involved 24 participants selected through purposive sampling, consisting of two main groups: healthcare professionals and patients. The healthcare professional group included 4 doctors, 4 nurses, and 4 midwives who were directly involved in medical services and patient communication processes. The patient group comprised 12 adult patients who were currently receiving or had previously received healthcare services at the selected Community Health Centers (Puskesmas). Participants were selected based on their active involvement in health communication, their relevance to the research objectives, and their capacity to provide rich qualitative data. This sample size is considered adequate for qualitative case study research, allowing for in-depth analysis, data saturation, and meaningful discourse interpretation within a Critical Discourse Analysis (CDA) framework. Data were collected using three primary techniques to ensure depth and richness of information.

First, limited participant observation was conducted during healthcare professional patient interactions, including consultations, medical examinations, and the delivery of treatment instructions. Observations focused on language choices, the use of medical registers, question-answer patterns, and patient responses. Second, semi structured interviews were conducted with both healthcare professionals and patients. Interviews with healthcare professionals explored their perceptions of language use, communication strategies, and challenges in conveying health information. Interviews with patients focused on their experiences of understanding medical information, comfort in communication, and perceived clarity of the health messages received. Third, document analysis was carried out on health communication materials used at the Puskesmas, including educational posters, health brochures, service

forms, and official social media content. These documents were analyzed to examine language consistency, readability levels, and the ideologies represented.

The collected data were analyzed qualitatively using Fairclough's Critical Discourse Analysis framework, encompassing the three dimensions of analysis. At the textual level, analysis focused on lexical choices, sentence structures, and the use of medical terminology. At the level of discursive practice, attention was directed to the processes of discourse production and consumption within healthcare professional patient interactions. At the level of social practice, analysis sought to reveal power relations, institutional ideologies, and social contexts shaping health communication practices. This analytical framework was integrated with sociolinguistic perspectives to examine language variation and linguistic accommodation strategies, as well as with the concept of health literacy to assess the impact of linguistic practices on patients' understanding and health related behaviors. Data validity was ensured through source and methodological triangulation.

RESULT AND DISCUSSION

This section presents and discusses the research findings based on observational data, interview transcripts, and document analysis of health communication practices at Community Health Centers (Puskesmas) in Depok City. The analysis is guided by Fairclough's Critical Discourse Analysis framework, encompassing the dimensions of text, discursive practice, and social practice, and is further informed by sociolinguistic perspectives and the concept of health literacy.

Textual Analysis: Language Choice and Medical Register

Text level analysis reveals a strong dominance of medical registers in healthcare professionals' speech. This is evident in the frequent use of technical terminology that is not consistently accompanied by simplified explanations or paraphrasing for patients. The following excerpt illustrates this pattern:

Doctor: *"Ibu mengalami hipertensi esensial, jadi tekanan darahnya harus dikontrol dengan anti hipertensi secara rutin."*

Patient: *"Oh iya, Dok..."*

In this interaction, the terms hipertensi esensial and anti hipertensi are employed without clarification in more accessible language. From a textual perspective, such lexical choices reflect a discourse orientation toward medical expertise and institutional authority. From a health literacy standpoint, the use of unelaborated technical terminology potentially constrains patient understanding, as indicated by the patient's minimal and non elaborative response. Similar patterns were observed in consultations related to chronic conditions, as shown in the following excerpt:

Doctor: *"Hasil lab menunjukkan kadar glukosa puasa Ibu cukup tinggi, mengindikasikan diabetes melitus tipe dua."*

Patient: *"Itu maksudnya bagaimana ya, Dok?"*

The use of terms such as glukosa puasa and diabetes melitus tipe dua reflects a formal medical register. Although the patient explicitly signals a lack of understanding, follow up explanations were not always provided in sufficient detail. Textually, this interaction highlights a gap between institutional medical language and patients' health literacy capacities. In contrast, some interactions demonstrated deliberate linguistic simplification and accommodation, as illustrated below:

Nurse: *"Tekanan darah Ibu sedang tinggi, jadi obat ini diminum setiap hari supaya tetap stabil."*

The use of non technical expressions such as Tekanan darah tinggi and the functional explanation of medication reflects a more patient oriented linguistic strategy. This accommodative approach prioritizes clarity and supports patient comprehension.

Further evidence of adaptive linguistic strategies can be seen in the following excerpt:

Midwife: *"Gula darahnya agak tinggi, Bu. Artinya kalau tidak dijaga, bisa bikin cepat capek dan sering haus. Makanya obat dan pola makannya harus diatur."*

Patient: *“Oh, jadi harus kurangi yang manis manis ya, Bu?”*

Here, medical concepts are simplified through cause effect explanations and concrete examples. From a health literacy perspective, this strategy enables patients to relate medical information to everyday experiences, facilitating better understanding and engagement. Overall, the textual analysis reveals a spectrum of language use in Puskesmas interactions, ranging from highly technical and exclusionary registers to more inclusive and communicative forms of expression. These variations indicate that the effectiveness of health communication is strongly influenced by lexical choices and healthcare professionals’ ability to adapt their language to patients’ social backgrounds and literacy levels. Additional findings also point to the use of bureaucratic abbreviations and procedural terminology that may be unfamiliar to patients, as illustrated below:

Doctor: *“Nanti Ibu kita lakukan rujukan ke FKRTL untuk USG lanjutan dan pemeriksaan lab lengkap.”*

Patient: *“FKRTL itu apa ya, Dok?”*

The use of institutional abbreviations such as FKRTL, combined with procedural terms like rujukan and USG lanjutan, results in dense informational packaging within a single utterance. While this reflects the efficiency of institutional discourse at the textual level, it poses challenges from a health literacy perspective. The patient’s request for clarification underscores the need for linguistic elaboration. These findings suggest that, beyond medical terminology, bureaucratic abbreviations also function as significant linguistic barriers in primary healthcare communication. Discursive Practice: Interactional Patterns and Meaning Production. At the level of discursive practice, healthcare professional patient interactions were predominantly characterized by one way communication. Healthcare professionals functioned as the primary producers of discourse, while patients were positioned largely as passive recipients. Question answer sequences were frequently dominated by closed ended questions, which restricted opportunities for patient participation and narrative expression. The following excerpt exemplifies this interactional pattern:

Doctor: *“Obatnya diminum dua kali sehari, ya. Ada pusing atau mual?”*

Patient: *“Tidak, Dok.”*

Such discursive practices indicate that meaning production is largely controlled by healthcare professionals. Patients tend to align themselves with the established communicative flow without initiating follow up questions or elaborations. From a sociolinguistic perspective, this interaction reflects a one way accommodation strategy, in which patients adjust to the institutional norms of the Puskesmas rather than actively shaping the interaction. However, in several cases, when healthcare professionals employed open ended questions and more dialogic language, patients demonstrated higher levels of engagement. This interactional shift positively influenced the process of meaning making in health communication. Additional data further illustrate discursive practices that are highly controlled by healthcare professionals through successive closed ended questions:

Doctor: *“Obatnya sudah diminum rutin? Tidak pernah lupa, kan?”*

Patient: *“Iya, Dok.”*

Doctor: *“Keluhan lain tidak ada?”*

Patient: *“Tidak ada.”*

In this example, the sequence of closed ended questions restricts patients’ opportunities to elaborate on their health experiences. At the level of discursive practice, meaning production is fully directed by the healthcare professional, while the patient is limited to minimal responses. From a Critical Discourse Analysis perspective, this pattern reproduces the patient’s position as a passive subject whose role is confined to confirming the healthcare professional’s assumptions. In contrast, the following interaction demonstrates a more dialogic and participatory discursive practice:

Nurse: *“Setelah minum obat ini, Ibu merasakan perubahan apa di badan?”*

Patient: *“Sekarang pusingnya sudah jarang, tapi kadang masih lemas.”*

Nurse: *“Baik, nanti kita catat. Menurut Ibu, bagian mana yang paling mengganggu aktivitas sehari hari?”*

In this interaction, the use of open ended questions provides discursive space for the patient to become a co producer of meaning within the medical discourse. At the level of discursive practice, meaning is negotiated between the healthcare professional and the patient. From sociolinguistic and health literacy perspectives, this communicative pattern encourages patient reflection on their own health condition and has the potential to enhance understanding and treatment adherence.

Social Practice: Power Relations and Institutional Ideology

At the level of social practice, health communication discourse in Puskesmas reflects institutional power relations between healthcare professionals and patients. Healthcare professionals are positioned as holders of authoritative medical knowledge, while patients are constructed as subjects expected to comply with instructions and procedures. The ideology of medical professionalism is evident in the emphasis on patient compliance with treatment regimens and institutional protocols. In this context, language functions as a mechanism for legitimizing institutional power. Patients with limited health literacy tend to accept information uncritically, with minimal negotiation of meaning, which may ultimately affect the quality of health related decision making. From a health literacy perspective, these social practices indicate that improving health literacy cannot be attributed solely to individual patient capabilities. Instead, it is also shaped by communicative structures and the ideological orientation of healthcare institutions. Consequently, transforming communication practices through linguistic simplification, two way dialogue, and recognition of patients' lived experiences becomes essential for improving the quality of public health services. To strengthen the findings, additional data are presented to illustrate variations in health communication practices at Puskesmas in Depok City. The following example demonstrates the use of imperative language reflecting power relations:

Doctor: "*Obat ini harus diminum habis. Jangan berhenti sebelum kontrol ulang.*"

Patient: "*Kalau sudah merasa sehat, tetap diminum ya, Dok?*"

Doctor: "*Iya, pokoknya ikuti aturan.*"

At the textual level, the use of imperatives such as must and follow the instructions signals medical authority. At the level of discursive practice, the interaction allows very limited negotiation of meaning. At the level of social practice, this discourse reproduces an ideology of patient compliance within the healthcare institution. Another example highlights differential communication strategies based on patient background:

Midwife: "*Ini imunisasi penting supaya anaknya tidak gampang sakit. Biasanya setelah disuntik bisa demam ringan, itu normal.*"

Mother: "*Oh, jadi kalau panas sedikit tidak apa apa ya, Bu?*"

Midwife: "*Iya, nanti bisa dikompres dan diberi obat sesuai anjuran.*"

This interaction demonstrates linguistic accommodation through cause effect explanations and anticipatory reassurance. From a health literacy perspective, such strategies assist patients in understanding potential risks and appropriate follow up actions.

In addition, limited register shifting was observed in certain interactions:

Nurse: "*Obatnya diminum pagi dan malam, jangan sampai lupa, ya Bu. Kalau pusing atau mual, langsung lapor ke kami.*"

The use of informal address forms (e.g., ma'am) and directive yet supportive expressions reflects an attempt to reduce social distance. From a sociolinguistic perspective, this register shift functions to build solidarity and enhance communicative comfort.

This section discusses the research findings derived from observational data, interview transcripts, and document analysis of health communication practices at Community Health Centers (Puskesmas) in Depok City. The analysis is theoretically grounded in Fairclough's Critical Discourse Analysis (CDA) framework, which conceptualizes discourse through three interrelated dimensions: text, discursive practice, and social practice. In addition, the interpretation is informed by sociolinguistic perspectives

and the concept of health literacy, allowing for a multidimensional understanding of how language, power, and knowledge operate within primary healthcare communication.

Textual Level: Language Choice, Medical Register, and Accessibility

At the textual level, the findings reveal a strong dominance of formal medical registers in healthcare professionals' speech. Technical terms such as *hipertensi esensial*, *anti hipertensi*, *glukosa puasa*, and *diabetes melitus tipe dua* are frequently used without systematic simplification, paraphrasing, or contextual explanation. From a discourse perspective, these lexical choices construct healthcare professionals as authoritative knowledge holders and reinforce institutional medical expertise. Language here functions not merely as a communicative tool but as a symbolic marker of professional authority and epistemic control. From a health literacy perspective, the unelaborated use of technical terminology creates communicative asymmetry. Patients' minimal responses (e.g., "Oh iya, Dok...") and explicit requests for clarification ("Itu maksudnya bagaimana ya, Dok?") indicate constrained comprehension and limited interpretive access to medical information. This supports the view that health literacy is not only an individual cognitive capacity but also a product of linguistic environments and communicative design. When technical language is not adapted to patients' linguistic and social backgrounds, understanding becomes structurally restricted rather than individually deficient.

However, the data also reveal linguistic accommodation strategies in some interactions. The use of simplified expressions such as *tekanan darah tinggi*, functional explanations of medication use, and cause-effect descriptions of symptoms represent communicative practices oriented toward patient comprehension rather than institutional efficiency. These strategies reflect a patient-centered discourse orientation, where clarity, accessibility, and relevance to everyday experience are prioritized. From a sociolinguistic perspective, this form of register adaptation constitutes downward accommodation, aligning professional language with patients' linguistic repertoires. Importantly, the findings also show that linguistic barriers are not limited to medical terminology. The use of bureaucratic abbreviations (e.g., *FKRTL*) and procedural terminology (*rujukan*, *USG lanjutan*) produces dense informational packaging that is institutionally efficient but communicatively opaque. This reveals that administrative discourse functions as an additional layer of linguistic exclusion. Thus, barriers to understanding are produced not only through biomedical language but also through bureaucratic institutional discourse, expanding the scope of health literacy challenges beyond clinical vocabulary alone.

Discursive Practice: Interactional Patterns and Meaning Production

At the level of discursive practice, healthcare interactions are predominantly characterized by one-way communication patterns. Healthcare professionals function as primary discourse producers, while patients are positioned as passive recipients. The dominance of closed-ended questions structures interactional sequences in a way that restricts narrative expression, elaboration, and patient agency. Meaning production is therefore professionally controlled, rather than dialogically negotiated. From a sociolinguistic perspective, this pattern reflects asymmetrical interactional accommodation, where patients adapt to institutional communicative norms instead of shaping interactional trajectories. Patients align with the expected response formats (short confirmations, minimal answers), which reproduces their subordinate discursive position. In CDA terms, this interactional structure constructs patients as discursively compliant subjects, whose primary role is confirmation rather than participation.

Nevertheless, the presence of open-ended questioning and dialogic interaction in some cases demonstrates alternative discursive formations. When healthcare professionals create discursive space for patients' narratives ("Setelah minum obat ini, Ibu merasakan perubahan apa di badan?"), patients become co-producers of meaning. Health communication shifts from transmission-based models to interactional meaning-making, where understanding is jointly constructed rather than unilaterally

delivered. This dialogic pattern aligns with participatory communication models, where patient reflection, narrative articulation, and experiential knowledge are recognized as legitimate components of medical discourse. From a health literacy perspective, such practices enable interpretive agency, allowing patients to integrate biomedical information with lived experience, which strengthens comprehension, engagement, and treatment adherence.

Social Practice: Power Relations, Institutional Ideology, and Compliance

At the level of social practice, health communication in Puskesmas reflects institutionalized power relations embedded in healthcare structures. Healthcare professionals are socially positioned as authoritative knowledge holders, while patients are constructed as compliant subjects expected to follow instructions, protocols, and institutional procedures. Imperative language (“*harus diminum habis*”, “*ikuti aturan*”) functions as a discursive mechanism of authority, legitimizing institutional power through linguistic form. These discursive patterns reproduce the ideology of medical professionalism, where compliance is framed as a moral and institutional expectation. From a CDA perspective, language here operates ideologically: it normalizes hierarchical relations and presents obedience as rational, necessary, and unquestionable.

From a health literacy perspective, this structure reveals that literacy is not merely an individual deficit but a structural product of institutional communication regimes. Patients’ limited negotiation of meaning is not simply a result of low literacy skills, but of communicative systems that prioritize efficiency, authority, and procedural control over dialogic understanding. However, instances of linguistic accommodation, reassurance strategies, and solidarity-building register shifts indicate micro-level resistance to institutional rigidity. These practices demonstrate that healthcare professionals are not monolithic agents of power but active negotiators within institutional discourse. Such interactions illustrate the possibility of transformative communication, where institutional authority is balanced with empathy, accessibility, and relational solidarity.

CONCLUSION

Linguistic choices in health communication at Puskesmas in Depok City significantly shape communication effectiveness between healthcare professionals and patients. The dominance of formal medical registers and technical terminology without adequate simplification creates communicative barriers that limit patient comprehension and participation, while simultaneously reinforcing professional authority and institutional discourse. From a health literacy perspective, such language practices restrict patients’ interpretive access to medical information, producing passive interactional roles and transmission-oriented communication. Conversely, the use of linguistic accommodation strategies through simplified vocabulary, contextual explanations, and everyday life examples enhances clarity, accessibility, and relevance, leading to increased patient understanding, engagement, and trust. Thus, communication effectiveness is determined by the balance between technical medical language and patient-oriented linguistic adaptation.

Power relations in Puskesmas health communication are constructed through institutional discourse, interactional asymmetry, and authoritative linguistic forms. Healthcare professionals occupy positions of epistemic and institutional authority, while patients are discursively positioned as subordinate and compliant recipients of information. This hierarchy is realized through the dominance of medical registers, bureaucratic terminology, directive speech acts, and imperative constructions that restrict dialogic space and control meaning production. At the level of social practice, such discourse reflects the ideology of medical professionalism, where authority and compliance are normalized, and institutional power is legitimized through everyday communicative routines, thereby reproducing hierarchical relations within primary healthcare interactions.

Levels of health literacy interact dynamically with linguistic accommodation strategies in shaping patient understanding, trust, and participation. Complex and technical language creates structural barriers to comprehension, producing passive interactional roles and limiting patient agency. Conversely, adaptive linguistic practices such as simplification, paraphrasing, register shifting, and contextual explanation enhance patients' access to, processing of, and engagement with health information. These strategies support functional and communicative health literacy, foster trust through reduced social distance, and expand patient participation as co-producers of meaning. Accordingly, health literacy emerges not as an individual capacity alone, but as a socially constructed outcome shaped by communicative design and institutional discourse.

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