Current definition and scope of health literacy and health literacy interventions

Focus
• Definitions (what)
• Interventions (how)

Task
• **Discuss (20 minutes in small groups)**
  • Definition(s) of health literacy in your context
  • What are the gaps?
  • How can we address these gaps in your country and your region?
• **Feedback to whole group (10 minutes)**
Building on the Shanghai Conference:
Improving health literacy for NCDs in the SDG-era
Workshop in preparation for the 1st meeting of WHO GCM/NCD
Working Group
on health education and health literacy for NCDs

Beijing, China
25-26 November 2016

Agenda

Conference Room 1, Fuwai Hospital, NOV 25 Fri, 2016, Beijing
Program

Day 1

• Shanghai Conference recommendations regarding Health Literacy:
  • how can health literacy contribute to the realization of the SDGs (in particular SDG 3, 3.4 and NCD-related SDGs)

• What is the current definition and scope of Health Literacy?

• Health Literacy for NCD prevention, management and prompting equality:
  • how to use health literacy to improve understanding and responses to NCDs?

• Presentation of 4 country cases from Working Group members on health literacy interventions on NCDs.

• What will optimal health literacy (status and responses) look like in 5-10 years?
  • What are the current gaps? What can be done to address the gaps?

• The role of health literacy measurement to drive improvement and accountability at different levels:
  • a comprehensive approach to support policy and practical actions for NCDs
Program (Continued)

Day 2

• Visit the facilitates of the National Clinical Research Centre

• Country-level and context-specific development, implementation and improvement of health literacy interventions
  • aimed at improving equity of access, service delivery and outcomes for people with low health literacy on NCDs, including e-health services for NCDs (for health services and communities).

• Cultural exchange
Health Literacy: several definitions

“An individual’s overall capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions” (US Institute of Medicine)

“The capacity of an individual to obtain, interpret and understand basic health information and services in ways that are health enhancing” (UK National Consumers Council)

“Health literacy represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health” (World Health Organization)

“Health literacy is the ability to make sound health decisions in the context of everyday life – at home, in the community, at the workplace, the healthcare system, the market place and the political arena” (Kickbusch, 2001)

People’s competences to access, understand, appraise and apply information to make health decisions in everyday life throughout the life course (Sorensen et al 2011)
Role of ‘health literacy’

• Health literacy is best thought of as a problem solving tool to assess and meet the needs of those who do not access or benefit from existing services and approaches as much as others

• It is deeply linked to the concept of equity and the concept that
  • not everyone has the same needs, and that
  • effective approaches are not the same for everyone.

• We have to do much more to change the responsiveness of the system
A critical concept: Health literacy is relative to the need for information

For example during the first few years of living with a chronic illness people often demonstrate large increases in knowledge of health issues and health services and a small increase in health literacy because their need for knowledge increases almost as fast as their knowledge.
Why health literacy? Why might it be useful?

1. QUICK WINS
   Large-scale impact from simple tasks.

2. DIMINISHING RETURNS
   from continued work on maturing campaign/programs

3. PLATEAU
   Flattened performance from stagnating campaign/programs

THEORETICAL MAXIMUM
100% coverage
no more improvement possible.

Optimising mass and/or standardised strategies
Why health literacy? Why might it be useful?

1. **QUICK WINS**
   - Large-scale impact from simple tasks.

2. **DIMINISHING RETURNS**
   - From continued work on maturing campaign/programs.

3. **PLATEAU**
   - Flattened performance from stagnating campaign/programs.

**THEORETICAL MAXIMUM**
- 100% coverage
- No more improvement possible.

But to be effective here we really need to focus on health literacy diversity.

Meeting the needs of those we are currently failing to engage or be effective with.

Optimising mass and/or standardised strategies.

To be effective here can think about average HL in the population.
How has health literacy been measured?

• Mostly been assessed through measuring reading ability, comprehension and word recognition skills

• Tools used with patients:
  1. Rapid Estimate of Adult Literacy in Medicine (REALM)
  2. Test of Functional Health Literacy in Adults (TOFHLA)
  3. Newest Vital Sign (NVS)

• Audits and surveys
  4. Audit of written materials / health facilities (e.g. signage)
  5. National Literacy Surveys

• New / Modern / multidimensional scales
Low functional health literacy has been associated with...

- increased health care costs
- higher prevalence of health risk factors
- increased death/mortality
- poorer medication adherence and increased adverse medication events
- participation in prevention activities
- poorer self-management of chronic diseases
- poorer disease outcomes
- less effective communication with health care professionals
- lower functional status
- poorer overall health status
- increased hospital admissions and readmissions
<table>
<thead>
<tr>
<th>Name</th>
<th>Domains reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinese Resident Heath literacy scale (Shen et al., 2015)</td>
<td>1. Knowledge and attitudes, 2. Behavior and lifestyle, and 3. Health-related skills</td>
</tr>
<tr>
<td>European health literacy survey (EU-HLS) (Sorensen et al., 2013)</td>
<td>1. Access, 2. Understanding, 3. Appraisal, and 4. Application of health information</td>
</tr>
<tr>
<td>Health literacy questionnaire (Osborne et al., 2013)</td>
<td>1. Feeling understood and supported by health care providers, 2. Having sufficient information to manage my health, 3. Actively managing my health, 4. Social support for health, 5. Appraisal of health information, 6. Ability to actively engage with health care providers, 7. Navigating the health care system, 8. Ability to find good health information, 9. Understand health information enough to know what to do</td>
</tr>
</tbody>
</table>

*aSee the Health Literacy Toolshed for a full list of published health literacy tests and scales [www.healthliteracy.bu.edu](http://www.healthliteracy.bu.edu).*

http://www.searo.who.int/entity/healthpromotion/documents/hl_toolkit/en/
Understanding needs for village-level health literacy interventions

Roy Batterham, Arnat Wannasri, Charay Vicathai, Anuchit Hirankitty, Richard Osborne
Health Insurance System Research Office (HISRO) Thailand
Health Systems Improvement Unit, Deakin University
Warin Chamrap District Hospital, Thailand
The fourteen core scales of the Information and Support for Health Actions Questionnaire (ISHA-Q)

1. Support for health in the community
2. Ability to access health services
3. Communication skills to get what you want from health professionals
4. Family support for health
5. Ability to access health information
6. Recognising rights
7. Evaluating trustworthiness of health information
8. Taking responsibility for own health
9. Physical/travel barriers to taking care of health
10. Eating for good health
11. Exercising for good health
12. Managing stress
13. Using medicines
14. Using herbs and supplements

Supports and abilities scales (37 questions)
Barriers scale (4 questions)
Health actions scales (19 questions)
## Potential individual and village level factors determining health literacy

<table>
<thead>
<tr>
<th>Individual factors</th>
<th>Village factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Education</td>
<td>• Health volunteers and nurses</td>
</tr>
<tr>
<td>• Intelligence</td>
<td>• Health leaders</td>
</tr>
<tr>
<td>• Personality types</td>
<td>• Infrastructure and food sources</td>
</tr>
<tr>
<td>• Experience with health services</td>
<td>• Community conversations and peer attitudes</td>
</tr>
<tr>
<td>• Family health habits</td>
<td>• Distance to health services</td>
</tr>
<tr>
<td>• Financial resources</td>
<td>• Traditional medicine providers</td>
</tr>
<tr>
<td>• Health</td>
<td></td>
</tr>
</tbody>
</table>
Asset-based model of health literacy

The more common use of the term ‘asset-based’ is in relation to development and is similar to ‘strengths-based’ and opposed to ‘needs-based’ or ‘deficit-based’. Applying this view to health literacy the health literacy assets of a community relate to the people resources, associations, institutions, physical assets and connections that enable people to understand and make decisions related to their health.

Source: Roy Batterham
Health Literacy
Responsiveness
(of organisations/services)
The health literacy responsiveness of services...

- Availability
- Accessibility

...interacts with...

...the health literacy of people making and supporting health decisions...

- Ability and willingness to engage with available information, environments, resources and supports
- Ability and willingness to communicate and assert decisions
- Ability and willingness to enact decisions and to solve problems appropriately

...and both influence the decisions made.

Health Literacy

Health Literacy Responsiveness
(of organisations/services)

Health Literacy
(of individuals)
Fig. 11. Elaborations on the foundations of a health-literate organization

Leadership promotes
Has leadership that makes health literacy integral to its mission, structure and operations

Plans, evaluates and improves
Integrates health literacy into planning, evaluation measures, patient safety and quality improvement

Prepares workforce
Prepares the workforce to be health literate and monitors progress

Ensures easy access
Provides easy access to health information and services and navigation assistance

Communicates effectively
Uses health-literacy strategies in interpersonal communication and confirms understanding at all points of contact

Includes consumers
Includes populations served in designing, implementing and evaluating health information and services

Meets everyone’s needs
Meets the needs of populations with a range of health literacy skills while avoiding stigmatization

Designs easy-to-use materials
Designs and distributes print, audiovisual and social media content that is easy to understand and act on

Targets high risk
Addresses health literacy in high-risk situations, including care transitions and communication about medicines

Explains coverage and costs
Communicates clearly what health plans cover and what individuals will have to pay for services

Org-HL Responsiveness Framework

1. External policy & funding environment
   - Financial management
   - Leadership & commitment
   - HL is an organisational priority
   - Equity & diversity focused
   - Consumer-centred philosophy

2. Leadership & Culture
   - Recruitment
   - Supportive working environments
   - Practice tools & resources
   - Ongoing professional development

   - Data collection & needs identification
   - Performance monitoring & evaluation
   - Service planning & quality improvement
   - Communication systems & processes
   - Internal policies & procedures

4. Program & Service Delivery
   - Service environment
   - Initial entry & ongoing access
   - Outreach services

5. Community Engagement & Partnerships
   - Community consultation & consumer participation
   - Partnerships with other organisations

6. Communication Practices & Standards
   - Communication principles standards
   - Health information provision
   - Use of media & technology
   - Health education programs

7. Workforce
   - Recruitment
   - Supportive working environments
   - Practice tools & resources
   - Ongoing professional development
WHO Framework on integrated people-centred health services

People-Centred Health

Resolution WHA69.24 “Strengthening integrated services” that supports the Framework on Health Services, was adopted with Member States at the Sixty-ninth World Health Assembly on 28 May in Geneva. This milestone event gives official mandate to work with its Member States to advance health service delivery reforms of the Framework.

IntegratedCare4People Web Platform Launched

May 2016 | Geneva -- At a Health Assembly WHO and School for Public Health, a web platform. The platform and leading practices, and services to become more into practitioners and organizations service delivery by curating resources that provide tech services can be transformative.

Read more about the launch

"Integrated people-centred health services means putting the comprehensive needs of people and
## Organisational –HL Responsiveness Framework

<table>
<thead>
<tr>
<th>Resource</th>
<th>WHO Health Systems Framework</th>
<th>WHO Framework on Integrated People-Centred Health Services (41)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. External policy &amp; funding environment</td>
<td>- Financi</td>
<td>- Strengthening governance &amp; accountability</td>
</tr>
<tr>
<td>2. Leadership &amp; culture</td>
<td>- Financi</td>
<td>- Strengthening governance &amp; accountability</td>
</tr>
<tr>
<td>3. Systems, processes, policies</td>
<td>- Information</td>
<td>- Strengthening leadership &amp; management for change</td>
</tr>
<tr>
<td>4. Program &amp; service delivery</td>
<td>- Service delivery</td>
<td>- Strengthening leadership &amp; management for change</td>
</tr>
<tr>
<td>5. Community engagement &amp; partnerships</td>
<td></td>
<td>- Equity focused</td>
</tr>
<tr>
<td>6. Communication practices &amp; standards</td>
<td></td>
<td>- Striving for quality improvement</td>
</tr>
<tr>
<td>7. Workforce</td>
<td>- Health workforce</td>
<td>- Reorienting the model of care</td>
</tr>
</tbody>
</table>

### Implementation principles
- Country-led
- Equity-focused
- Participatory
- Evidence-based
- Systems strengthening
- Results-oriented
- Ethics-based
- Sustainable
The e-health literacy framework: A conceptual framework for characterizing e-health users and their interaction with e-health systems

Ole Norgaard
University of Copenhagen, Denmark

Dorthe Furstrand
University of Copenhagen, Denmark

Danish Cancer Society, Copenhagen, Denmark

Louise Klokker
Bispebjerg & Frederiksberg Hospital, Denmark

Astrid Karnoe
University of Copenhagen, Denmark

Roy Batterham
Deakin University, Melbourne, Australia

Lars Kayser
University of Copenhagen, Denmark

Richard H. Osborne
Deakin University, Melbourne, Australia
Domain names and descriptors of the eHLQ

1. **Ability to process information**
   Able to read, write and remember, apply basic numerical concepts, and understand context-specific language (e.g. health, IT or English) as well as critically appraise information. Know when, how and what information to use.

2. **Engagement in own health**
   Know about basic physiological functions and own current health status. Aware of risk factors and how to avoid them or reduce their influence on own health as well as navigating the health care system.

3. **Ability to actively engage with digital services**
   Being comfortable using digital services for handling information.

4. **Feel safe and in control**
   Feel that you have the ownership of personal data stored in the systems and that the data are safe and can be accessed only by people to whom they are relevant (own doctor, own nurse etc.).

5. **Motivated to engage with digital services**
   Feel that engaging in the use of digital services will be useful for them in managing their health.

6. **Access to digital services that work**
   Have access to digital services that the users trust to be working when they need it and as they expect it to work.

7. **Digital services that suit individual needs**
   Have access to digital services that suit the specific needs and preferences of the users. This includes responsive features of both IT and the health care system (including carers) as well as adaptation of devices and interfaces to be used by people with physical and mental disabilities.
eHealth Literacy Framework

- 1. Ability to process information
- 2. Engagement in own health
- 3. Ability to actively engage with digital services
- 4. Feel safe and in control
- 5. Motivated to engage with digital services
- 6. Access to digital services that work
- 7. Digital services that suit individual needs
Demonstration sites

• Stemmed from case study from Erika Placella (Swiss)
• Needs assessment to inform community consultations and intervention development
  • Health literacy assessment
• Health Literacy Intervention development described in the WHO-SEARO Health Literacy Toolkit for Low- and Middle-Income Countries
The Ophelia approach is a system that supports the identification of community health literacy needs, and the development and testing of potential solutions. It allows easy application of evidence-based health promotion approaches to the field of health literacy.
Australian Research Council Linkage Grant (2012-2015)

Key investigators
- Richard Osborne
- Rachelle Buchbinder
- Roy Batterham
- Alison Beauchamp
- Sarity Dodson
- Brad Astbury
- Gerald Elsworth

Partners – Victorian Government
1. Home and Community Care (HACC)
2. Primary Care
3. Hospital Admissions Risk Program (HARP)

www.ophelia.net.au
Ophelia protocol

The protocol draws on three discourses:
1. Intervention mapping
2. Quality improvement collaboratives
3. Realist evaluation thinking

http://www.biomedcentral.com/1471-2458/14/694
The Ophelia phases: 1 to 3

Each phase of the Ophelia process is drawn from three well-established methodological approaches: intervention mapping, quality improvement collaboratives, and realist synthesis. Tools and resources have been developed to support implementation of each phase.

Phase 1
Identifying the health literacy strengths and limitations of the local community

Phase 2
Co-creation of health literacy interventions

Phase 3
Implementation, evaluation and ongoing improvement

Health literacy data are systematically collected from a representative cross section of the community using a health literacy questionnaire and/or locally appropriate qualitative techniques. These data are analyzed and presented to stakeholders for discussion and interpretation. Effective local practices and innovative intervention ideas are then identified.

Local stakeholders make decisions about local priorities for action. Interventions with potential to respond to local health literacy limitations or improve information and service access and availability are designed and planned.

Health literacy interventions are applied within quality improvement cycles, where organizations develop and implement trials, and actively improve the effectiveness, local uptake and sustainability of the interventions.
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Implementation, evaluation and ongoing improvement

Health literacy interventions are applied within quality improvement cycles, where organizations develop and implement trials, and actively improve the effectiveness, local uptake and sustainability of the interventions.
Ophelia’s Principles

1. Focus on improving health and wellbeing outcomes
2. Respond to locally-identified health literacy needs
3. Focus on increasing equity in health outcomes, and access to services for people with varying health literacy needs
4. Prioritise local wisdom, culture and systems
5. Engage all relevant stakeholders in the co-creation and implementation of solutions.
6. Focus on improvements at, and across, all levels of the health system
7. Focus on achieving sustained improvements through changes to environments, practice, culture and policy
8. Respond to the variable and changing health literacy needs of individuals and communities

www.ophelia.net.au
The fourteen core scales of the Information and Support for Health Actions Questionnaire (ISHA-Q)

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12. Managing stress
13. Using medicines
14. Using herbs and supplements

Supports and abilities scales (37 questions)
Barriers scale (4 questions)
Health actions scales (19 questions)

Health Literacy Toolkit
World Health Organization
Regional Office for South-East Asia
Multi-dimensional tools for measuring health literacy

The Health Literacy Questionnaire (HLQ) is used to identify the specific health literacy strengths and limitations of people and communities. It examines nine areas of health literacy. The HLQ offers the potential for practitioners, organizations and governments to identify and understand the health literacy profiles of individuals and/or populations as a basis for intervention development. It is suitable for use in a range of different cultures and is available in several languages.\(^1\)\(^2\)

Link: www.ophelia.net.au

**Key resource:**

Link: http://www.biomedcentral.com/1471-2458/13/658

The nine scales of the Health Literacy Questionnaire (HLQ)\(^2\)
Advantages of working with practitioners and community members

- Years of experience and tacit knowledge are important resources
  - knowledge of local situations
  - knowledge of people
- Likely to be implementable
  - co-designed *in situ* with all stakeholders
- Don’t need to achieve subsequent buy-in
  - Don’t need to convince them it’s a good idea... it’s their idea!
Health literacy in a global transition to sustainable development

- Transition to a **focus on equity and targeting strategies to the people rather than people for our strategies**

- Transition to **local input into decisions that affect local sustainability**
  - Need to build capacity for people in communities to consider all the ways that development decisions affect their health and well-being and to participate effectively in decision-making (e.g. SDGs that relate to water use, land use, ocean use, energy systems, transport systems)

- Transition to **critical resistance**
  - Messages affecting how people think and act about health that come from product advertising far outweigh the volume of health promotion messages. People and communities need the skills to resist this bombardment and still make healthy choices

- Transition to **choice**
  - Many countries are achieving some level of universal healthcare coverage giving segments of the population access to services they have not had access to before. In addition the number of programs for specific target groups continues to multiply

- Transition to **daily health management**
  - Increasingly the most prevalent health issues (e.g., NCDs) require people to integrate management of their health with the normal demands of daily life and the requirements of their family and community
Areas of health literacy work across settings

1. **National level**
   - Cross national comparisons for advocacy for national prioritization of health literacy

2. **Policy makers**
   - Health literacy of policy makers including across sectors

3. **General public**
   - Health literacy for mass communication

4. **Youth**
   - Schools, child and adolescent health literacy

5. **Service users**
   - Health literacy to enable particular service delivery models (e.g. patient-centred care, eHealth)

6. **Healthcare staff**
   - Health literacy and behavior change competencies of healthcare staff

7. **Underserved population groups**
   - Health literacy for targeting and solving problems related to ‘hard-to-reach’ groups

8. **Service users**
   - Health literacy as a means of enabling consumer choice and self-direction

9. **General public/Community level**
   - Enabling community action on health

10. **General public/Community level**
    - Health literacy and the formation of community beliefs and attitudes about health
Ophelia Process to build a Health Literacy Response Framework

Local stakeholders identify local priorities

Document local needs (HLQ)

Uncover local wisdom (practice excellence)

Share local wisdom
- Co-develop framework
- Community of practice

Implement Local pride, test, learn, evaluate, feedback, compare

Build knowledge hub
Narratives, practical, context relevant
4. The role of health literacy measurement to drive improvement and accountability at different levels: a comprehensive approach to support policy and practical actions for NCDs (10:35 – 12:15)

National health literacy surveys: an essential tool for strengthening political commitment and interventions
If you can't measure it, you can't improve it
My involvement in the measurement field

- Academic background
  - Epidemiologist, health services researcher, qualitative expertise
  - 20 years experience with population-based surveys through to clinical outcomes measures
- Developed several questionnaires used globally
  - Knowledge, coping / self-management, symptoms, health literacy
- Author of 4 health literacy surveys
  - HeLMS (health literacy management scale)
  - HLQ (health literacy questionnaire)
  - EU-HLQ (European Health Literacy Survey)
  - ISHAQ (Information and support for health questionnaire)
- Personally conducted >120 questionnaire translation and cultural adaptation exercises
Two approaches to thinking about health literacy

1. **Narrow approach:**
   - research oriented
   - literal concept of ‘literacy’
   - focused on precise definition of the construct and distinguishing it from other precise psychometric constructs (e.g. patient activation)

2. **Broad approach:**
   - practically oriented
   - metaphorical concept of ‘literacy’ (like computer literacy or financial literacy)
   - focused on being inclusive and identifying all the factors required for people to make effective decisions in matters that affect their health
How has health literacy been measured?

• Mostly been assessed through measuring reading ability, comprehension and word recognition skills

• Tools used with patients:
  1. Rapid Estimate of Adult Literacy in Medicine (REALM)
  2. Test of Functional Health Literacy in Adults (TOFHLA)
  3. Newest Vital Sign (NVS)

• Audits and surveys
  4. Audit of written materials / health facilities (e.g. signage)
  5. National Literacy Surveys

• New / Modern scales
Rapid Estimate of Adult Literacy in Medicine: REALM

<table>
<thead>
<tr>
<th>List 1</th>
<th>List 2</th>
<th>List 3</th>
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<tr>
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<td>notify</td>
<td>sexually</td>
</tr>
<tr>
<td>germs</td>
<td>gallbladder</td>
<td>alcoholism</td>
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Test of Functional Health Literacy in Adults: TOFHLA

Numeracy (17 items)

<table>
<thead>
<tr>
<th>Abbocillin VK Tablets 250mg</th>
<th>50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take ONE tablet by mouth four times a day</td>
<td></td>
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</tbody>
</table>

Mr Ian Garfield  
nil Rpts  
16/04/06 Dr Michael Lubin FF941858  
$11.53

Q1. If you take your first tablet at 7.00am, when should you take the next one? __________

Q2. And the next one after that? __________

This information is on the back of a container of a pint of ice cream.

QUESTIONS
1. If you eat the entire container, how many calories will you eat?

Answer: 1,000

Health literacy is:
more than reading and writing
Health Literacy: several definitions

“An individual’s overall capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions” (US Institute of Medicine)

“The capacity of an individual to obtain, interpret and understand basic health information and services in ways that are health enhancing” (UK National Consumers Council)

“Health literacy represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health” (World Health Organization)

“Health literacy is the ability to make sound health decisions in the context of everyday life – at home, in the community, at the workplace, the healthcare system, the market place and the political arena” (Kickbusch, 2001)

People’s competences to access, understand, appraise and apply information to make health decisions in everyday life throughout the life course (Sorensen et al 2011)
Using health literacy to solve problems...

Access issues
- Why do some groups of people **not** engage in free cancer screening?
- Why do some people present late for CVD treatment?
- Why do some people not engage in Universal Health Coverage?

Treatment issues
- Why do people not participate in CVD rehabilitation programs?
- How can we encourage more people to complete TB treatments?
  - Andalas University Medical Centre, Padang, Indonesia

Complex problems
- Why to people keep coming back to the ED with Primary Care Preventable Admissions?
  - Melbourne, Australia
- What do older people with NCDs in rural Thailand need to be able to self-manage?
  - Ubon Ratchathani, Thailand
- What do people need to be able to engage in diabetes treatment when having a diagnosis of diabetes is shameful?
How might health literacy develop at individual or community level?

1. **Building health knowledge.**
   Knowledge comes from reading about health, media, talking with health professionals, friends and family.

2. **Developing health literacy skills** e.g. using computer to seek information, critical analysis of information, self-management skills such as understanding medication.

3. **Displaying health literacy actions** e.g. asking for information and services, requesting medications, or being involved in discussions with health providers.

4. **Making an informed decision** e.g. making shared and deliberate decisions about treatments or self-management tasks.
The more common use of the term ‘asset-based’ is in relation to development and is similar to ‘strengths-based’ and opposed to ‘needs-based’ or ‘deficit-based’. When applying this view to health literacy, the health literacy assets of a community relate to the people resources, associations, institutions, physical assets and connections that enable people to understand and make decisions related to their health.

A traditional healer comes to village sometimes but is expensive

Not many family members around who understand

Not sure what diabetes is and why it is important to him

What can be built upon?

What assets can be added?

Source: Batterham, Osborne
The more common use of the term ‘asset-based’ is in relation to development and is similar to ‘strengths-based’ and opposed to ‘needs-based’ or ‘deficit-based’. When applying this view to health literacy, the health literacy assets of a community relate to the people resources, associations, institutions, physical assets and connections that enable people to understand and make decisions related to their health.

Source: Batterham
# Purposes for health literacy measurement and analysis at different levels

<table>
<thead>
<tr>
<th>Levels at which health literacy can be measured</th>
<th>Potential purposes for measuring health literacy</th>
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</thead>
<tbody>
<tr>
<td><strong>Health service settings</strong></td>
<td>As per the table above.</td>
</tr>
<tr>
<td>1. Individual patients</td>
<td>- To solve problem for complex patients</td>
</tr>
<tr>
<td>2. Patient groups</td>
<td>- To train staff in responding to differing health literacy needs</td>
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<tr>
<td>3. Individual health services</td>
<td>- To identify common factors that contribute to poor access and health outcomes</td>
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<tr>
<td><strong>Community and population settings</strong></td>
<td>- To plan for services to respond to health literacy needs</td>
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<tr>
<td>4. Local areas (both health and community services/authorities)</td>
<td>- To inform advocacy activities</td>
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<tr>
<td>5. National surveys (to compare regions and groups)</td>
<td>- To plan marketing and education strategies across services</td>
</tr>
<tr>
<td>6. Countries (international comparisons)</td>
<td>- To assess the ability of community members to participate in community-based health planning activities (critical health literacy) and develop suitable approaches to enable their participation</td>
</tr>
</tbody>
</table>

### HL measurement in community and population settings

| 4. Local areas (both health & community services/authorities) | - To plan marketing and education strategies across services  
- To assess the ability of community members to participate in community-based health planning activities (critical health literacy) and develop suitable approaches to enable their participation |
|---|---|
| 5. National surveys (to compare regions and groups) | - To identify relationships between health literacy and access, equity and outcomes, in order to develop appropriate health service and public health policies and strategies  
- Plan health education campaigns, or campaigns to support the introduction of new services, screening initiatives (e.g., bowel or skin cancer) or vaccination programs.  
- Assess regional “patient difficulty” for planning and funding purposes (assuming that it takes more intensive resources to improve health outcomes for people with low health literacy than it does for people with higher health literacy) |
| 6. Countries (international comparisons) | - Advocacy for governments in countries where there is systemic low health literacy  
- Identify countries that are role models for how to improve health literacy levels of populations |
Important considerations regarding measuring health literacy

• People with low health literacy don’t like filling in surveys
  • Stigma, shame, fatigue, cognitive issues
• Health literacy is multidimensional
  • Understand, access, use
• Health literacy locus (self vs communal/distributed)
  • Decision making in communal societies are different to Western
• There is no ‘threshold’ for low or high health literacy
• Health literacy is context dependent
  • Expectations
  • Prior experience
  • The more challenging the environment, the higher the need for health literacy
  • The more demanding the citizen is, the higher their expectations of good service, and the lower they rate the quality of the service
An integrative model of health literacy
Batterham, Osborne et al
Health literacy survey–European Union

Fig. 8. Percentage distributions of general health literacy for each country and the 7795 respondents


9. Understanding health information well enough to know what to do

6. Active engagement with healthcare providers
Health literacy of Chinese, Somali and Indian immigrants

[Box plot image showing comparisons between Chinese, Somali, and Indian immigrants across different HLQ scales.]
A ‘settings’ based approach
Systems/organisational perspective

Fig. 11. Elaborations on the foundations of a health-literate organization


WHO regional office for Europe, 2013. Health literacy: The solid facts
Assess everyone versus assess no-one versus the ‘middle way’
Universal precautions...versus

Providers don’t always know which patients have limited health literacy. Some patients with limited health literacy:

- Have completed high school or college
- Are well spoken.
- Look over written materials and say they understand. Hold white collar/professional or health care jobs
- Function well when not under stress.

Recommend assuming that everyone may have difficulty understanding and creating an environment where patients of all literacy levels can thrive. In the case of health literacy universal precautions, primary care practices should ensure that systems are in place to promote better understanding for all patients, not just those you think need extra assistance

http://www.nchealthliteracy.org/toolkit/
...screening health literacy

Psychometric Properties of the Brief Health Literacy Screen in Clinical Practice

Kenneth A. Wallston, PhD, Courtney Cawthon, MPH, Candace D. McNaughton, MD, MPH, Russell L. Rothman, MD, MPP, Chandra Y. Osborn, PhD, MPH, and Sunil Kripalani, MD, MSc

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1. How confident are you filling out medical forms by yourself?
2. How often do you have someone help you read hospital materials?
3. How often do you have problems learning about your medical conditions because of difficulty understanding written information

Validated in terms of its association with the S-TOFHLA
Why we are not advocating screening

- Many people with problems will be screened as OK (false negative rates)
- Screening test has a relatively weak association with another test which is, itself, a limited measure of health literacy
- Health literacy is a relative concept and changes with changed circumstances – ongoing sensitivity is more important than single point measurement
- Competes with other screening priorities
- Induces stigma, feelings of shame (if illiterate)
- People who can’t read are not ‘health illiterate’ (i.e., have zero score on health literacy competency)
Elements of the Universal Precautions Toolkit

Includes tools to:

1. Improve spoken communication (e.g. teach-back methods)
2. Improve written communication (e.g. guidelines and audit of written materials)
3. Improve self-management and empowerment
4. Improve supportive system

http://www.nchealthliteracy.org/toolkit/

but...

All of these, and especially 3 and 4, can be improved by:

a. Understanding common health literacy needs of target group(s)
b. Understanding the range of health literacy needs of target group(s)
A middle way: informed universal precautions

1. Measure and describe health literacy needs of your target population (whether or not they attend services)
2. Utilise health literacy measurement to increase sensitivity and the repertoire of responses of staff
3. Prioritise and guide the use of toolkit tools and other tools
4. Provide a structure for synthesising local wisdom and the experience of the best practitioners