

Editorial

Health Literacy—Identification and Response

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The term “health literacy” has now permeated the public health lexicon. The 2006 U.S. National Assessment of Adult Literacy (NAAL) is the first national survey to employ assessment tasks conducted specifically to measure the health literacy of adults living in the United States. These landmark data provide results on the scope of overall literacy and health literacy in America with a survey of over 19,000 U.S. adults.

The health literacy scale and health literacy tasks were guided by the definition of health literacy accepted by the U.S. Institute of Medicine and Healthy People 2010 that states that health literacy is: “The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions (HHS, 2000; Ratzan & Parker, 2000; Institute of Medicine, 2004).

Similarly, across the Atlantic, the UK government also embraced the U.S. definition. The UK Committee on Safety of Medicines highlighted this concept is a useful tool in identifying problems in communicating health information and enabling people to use that information to make health decisions. They further emphasized a component they called medication literacy, referring to the range of skills needed to access, understand and act on medicines information (Medicines and Healthcare Products Regulatory Agency, 2005).

The most recent U.S. study employed a scale of 0 to 500 for overall literacy and for health literacy, and categorized skills in four performance levels: Below Basic, Basic, Intermediate, and Proficient. Official reports of the health literacy survey emphasized that the majority of adults (53%) had Intermediate health literacy. About 22% had Basic and 14% had Below Basic health literacy. The complete report is available at <http://nces.ed.gov/pubs2006/2006483.pdf>. Additionally, adults in the oldest age group—65 and older—had lower average health literacy than adults in younger age groups. Adults ages 25 to 39 had higher average health literacy than adults in other age groups.

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A closer examination of the recent survey reveals that the average score for health literacy skills (245, Intermediate range) was significantly lower than the average overall literacy scores (271 and 275, Intermediate range for document and prose; 283 for quantitative, Intermediate range). Literacy experts have long noted that literacy skills are context and content specific, and thus these results should not be surprising. Someone can have adequate literacy skills in one domain, and significantly worse skills in another. The literacy demands of health tasks are daunting for many.

What does it mean that 53% of Americans have Intermediate health literacy? Over one-third of American adults, over half of the elderly, three-fourths of high school drop outs and over half of those with public or no health insurance cannot figure out what time to take a medication based on label instructions. They also cannot identify three substances that may interact with an OTC medication to cause a side effect based on the information on the label, or use a CDC vaccine information chart to find the appropriate age range for a child to receive a vaccine. When looking at a graph that relates height and weight to body mass index, they cannot figure out a healthy weight range.

Over one-third of Americans — or 36% — with Below Basic or Basic health literacy were less likely than adults with higher health literacy to get information about health issues from written sources (newspapers, magazines, books, brochures, or the Internet) and more likely than adults with higher health literacy to get a lot of information about health issues from radio and television. This applied to a variety of health literacy tasks that were organized around three domains of health and health care information and services: clinical, prevention, and navigation of the health care system.

So What Does All This Mean?

The results of NAAL have many implications that will be digested and discussed in various arenas. Unfortunately, results show that literacy skills of American adults have not changed dramatically over the last decade. The average skills of U.S. adults are not adequate for understanding and using the health system. Data from the survey will provide for a baseline for the *Healthy People 2010* objective, but the survey instrument and data are owned by the U.S. Department of Education, and there is no ability to access the raw data or survey questions. Although health literacy has gained growing attention in the U.S., there is no on-going population based survey of health literacy within the health sector, and the only population based effort to measure health literacy captures only individuals' skills of print materials. There remains a pressing need to advance population-based measures and indicators of a health literate public for national and international use (Parker & Kindig, 2006).

Health literacy skills are needed for dialogue and discussion, reading health information, interpreting charts, making decisions about participating in research studies, using medical tools for personal or family health care—such as a peak flow meter or thermometer—calculating timing or dosage of medicine, or voting on health or environment issues (Institute of Medicine, 2004). As the Committee on Health Literacy of the Institute of Medicine wrote:

Health literacy is of concern to everyone involved in health promotion and protection, disease prevention and early screening, health care maintenance, and policy making.

In short, it reminds health communicators of the need to tailor information, messages and advice while choosing the appropriate media to enhance quality decision-making. This includes addressing the challenge to communicate complex health information to different groups in the population, addressing the comprehension of risk, benefits and safety while providing practical support for those of all literacy levels.

The ideas for addressing limited health literacy—perhaps reframing this as a health competence all should aspire to—requires health communicators to employ all the available means of persuasion to support the provision of the right information available at the right time with the support people need to use it to make appropriate health decisions.

This will require a Health Information strategy to address disparities, disadvantaged groups, linguistic and cultural sensitivity and other areas. Further, a commitment to be innovative—promulgating a policy of empowerment as a way of enabling people to access and use health information will be a challenge for all stakeholders in society (Parker, Ratzan, & Lurie, 2003).

The articles in the Journal continue to challenge us to extract the ideal evidence base to advance health prudently. In our quest for optimal influence, it is incumbent upon all of us to consider the health literacy level in the development of health campaigns, messages, health professional relationships and in the communication of health policy and moral imperatives of the 21st Century.

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