

PRIORITIES FOR ACTION

Outcomes from the National Symposium on Health Literacy



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National Symposium on Health Literacy
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ISBN: 978-1-897485-02-6

This publication is also available from www.cpha.ca.

Canadian Public Health Association
400-1565 Carling Avenue
Ottawa, Ontario K1Z 8R1
Tel: 613.725.3769
Fax: 613.725.9826
Email: info@cpha.ca

The Canadian Public Health Association is a national, independent, not-for-profit, voluntary association representing public health in Canada with links to the international public health community. CPHA's members believe in universal and equitable access to the basic conditions which are necessary to achieve health for all Canadians

Priorities for Action

Outcomes from the National Symposium on Health Literacy

The Canadian Public Health Association (CPHA) established an Expert Panel on Health Literacy in spring 2006 to investigate and recommend ways to improve health literacy in Canada. Health literacy involves the skills needed to get, understand and use information to make good decisions for health.

The Expert Panel concluded that a large number of adults have low health literacy. Statistics Canada estimates that 48% of adults over age 16 have low literacy and numeracy skills. The Panel suspects that the percentage with low health literacy is even higher. Low literacy is linked with poor health outcomes and restricts participation in society and the economy. Health literacy is vital to health promotion.

The Panel calls for a comprehensive national strategy to help raise levels of health literacy and support Canadians in coping with health information demands. With an eye to the March 3, 2008 release of the Panel's report, CPHA and the National Collaborating Centre for Determinants of Health organized a health literacy symposium on January 9 & 10, 2008 in Ottawa.

At the symposium, practitioners, policymakers and researchers with a range of views about literacy, health and learning envisioned where we could be five years from now if Canada had an effective nationwide health literacy strategy.

These are the key recommendations for a successful strategy:

1. The following principles are fundamental to the pan-Canadian health literacy strategy:
 - health literacy is an issue of social equality
 - solutions are embedded in existing structures
 - literacy begins early in childhood and is strengthened over time
 - adult literacy learners are engaged in the development of solutions
 - diverse needs and cultures are recognized and respected
2. Make health and education sensitive and responsive to language, culture and health literacy.
3. Establish literacy as a national priority, with health literacy as part of that agenda.
4. Develop programs that enable priority populations to make better use of health services.
5. Encourage and support health practitioners and professionals to be agents of change.

6. Design and implement an integrated and comprehensive Aboriginal strategy that addresses the needs and concerns of First Nations, Inuit and Métis populations, regardless of residency.
7. Determine research and evaluation priorities.

Health Literacy Symposium Participants

Over 60 participants attended the health literacy symposium in January 2008. Practitioners, researchers and policymakers from non-governmental organizations, health, public health, education, and provincial and federal government shared their views, including representatives of the following:

50 Plus.Net International
 Active Living Coalition for Older Adults
 BC Academic Health Council
 Canadian Association for School Health
 Canadian Association of Social Workers
 Canadian Cancer Society
 Canadian Council on Learning
 Canadian Dental Assistants' Association
 Canadian Dental Hygienists Association
 Canadian Ethnocultural Council
 Canadian Medical Association
 Canadian Multicultural Health Promotion Society
 Canadian Patient Safety Institute
 Canadian Pediatric Association
 Canadian Pharmacists Association
 Canadian Public Health Association
 CATALIST, The Canadian Network for Third Age Learning
 Health and Learning Knowledge Centre, Canadian Council on Learning
 Heart and Stroke Foundation of Canada
 Indigenous Physicians Association of Canada
 Movement for Canadian Literacy, Learners Advisory Network
 Mood Disorders Society of Canada
 Movement for Canadian Literacy
 Nova Scotia Department of Health
 Provincial Language Service, BC Health Services Authority
 Regroupement des intervenantes et intervenants francophones en santé
 Réso-Santé – Colombie-Britannique
 Society of Obstetricians and Gynecologists of Canada, Aboriginal Health Initiatives
 The Centre for Literacy of Quebec
 University of Regina Seniors Education Centre
 Victorian Order of Nurses

Background for the Symposium

The following summary was prepared by Susan Sullivan, CPHA Project Manager, and distributed to symposium participants. This information focuses on issues that were expected to be relevant to the symposium discussion. Health literacy involves the ability to access, understand, communicate and act on information for health. It is related to, but different than, literacy.

Literacy and Health Literacy

Health literacy is a relatively new field of study and its concept has evolved over the past 30 years. Health literacy is closely related to literacy, which is also a concept that has evolved significantly over time.

Literacy

At one time, literacy was considered the ability to sign one's name. Later, being literate meant the ability to read and write—what some today might term “basic literacy.” More recently, the concept of literacy has broadened to become a multifaceted skill, which can be developed to different levels and which can strengthen or fade over time.

Literacy is now widely considered to be the knowledge, skills and ability essential to social and economic participation in Canadian society. UNESCO defines functionally literate persons as those who can engage in all activities for which literacy is required within their community and which enable them to continue to use reading, writing and calculation for their own and their community's development (UNESCO, 2003).

Researchers have long known of the link between literacy and health. Literacy and education are both considered key determinants of health, along with income, employment, working conditions and the social environment.

Measuring Literacy

The 2003 International Adult Literacy and Skills Survey (IALSS) tested a nationally-representative sample of more than 23,000 people aged 16 and over from across the country. The survey assessed competence in four skill domains: prose literacy, document literacy, numeracy, and problem solving. Prose literacy is the knowledge and skills needed to understand and use information from texts; document literacy relates to locating and using information contained in materials; numeracy is the knowledge and skills required to apply arithmetic operations embedded in printed materials; and problem-solving is planning and analytical reasoning to reach a defined goal.

The IALSS test scores range from 0 to 500 points and are grouped into four levels of competence, from a low of Level 1 to a high of Level 4/5. (Levels 4 and 5 were combined into one group due to the small number of respondents who tested at Level 5.) Scores along the 500-point scale indicate that a person has an 80% probability of correctly answering a task at that level of difficulty. Although disputed by some, Statistics Canada deems Level 3 on prose literacy, document literacy and numeracy as the minimum level required to understand and use information in order to function effectively in society and the economy. People who score at Level 1 or Level 2 in these domains “typically have not yet mastered the minimum foundation of literacy needed to attain higher levels of performance” (Strucker & Yamamoto, 2005 cited in Statistics Canada and Human Resources and Skills Development Canada, 2005, p. 14). Statistics Canada has not yet determined a “desirable” threshold for problem-solving skills.

The 2003 IALSS estimates that 48% of Canadians over age 16 score below Level 3 on prose and document literacy. In addition, Francophones, Aboriginal people, immigrants and people over age 65 tended to have lower test scores in general. (People living on reserves were not included in the sample.) (Statistics Canada & HRSDC, 2005).

Other major findings from the IALSS include:

- Document literacy proficiency tends to decrease with age
- Proficiency in literacy and employability are clearly linked
- 60% of adult immigrants scored below Level 3 in prose literacy, compared to 37% of Canadian-born
- Literacy scores did not improve between 1994 and 2003, despite an increase in the formal education levels
- People aged 16 to 65 who reported being in poor health had lower average scores than those who said they were in fair, good or excellent health (Statistics Canada & HRSDC, 2005).

Health Literacy

Early definitions of health literacy tended to focus on patients’ ability to read and understand health care information and their compliance with medical instructions. Later, definitions broadened to include the ability to access health information, make informed choices, personal empowerment and the importance of context.

The WHO Health Promotion Glossary (Nutbeam, 1998) defines health literacy as “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” (p. 10). The Glossary goes on to say that health literacy “means more than being able to read pamphlets and make appointments” but rather “implies the achievement of a level of

knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions.” (p. 10)

As modern health systems have become increasingly complex in all components, Kickbusch (2001) notes that a wide range of knowledge and skills are required to respond adequately in times of illness, so health literacy involves understanding and ability to judge, sift and use information provided in the context of one’s own life.

Measuring Health Literacy

Currently, there is no measure of health literacy that reflects the broad range of skills captured in the definitions above. Health literacy encompasses more than what is assessed by literacy tests. None of the measures currently used include oral communication skills, listening or writing skills. None measures the health literacy demands on individuals within different health contexts, different cultural approaches to health and health care, or background knowledge in health domains, such as biology or nutrition.

Of the three most widely used health literacy assessment tools, two were developed for use by researchers in clinical settings: the Rapid Estimate of Adult Literacy in Medicine (REALM, Davis et al., 1993, cited in Columbia University); and the Test of Functional Health Literacy in Adults (TOFHLA, Parker et al., 1995, cited in Columbia University). REALM is a medical-word recognition and pronunciation test comprising 66 medical terms, which takes less than two minutes to administer. TOFHLA measures the numeracy and reading comprehension level of patients, using health care materials, such as patient education information, prescription bottle labels, registration forms, and instructions for diagnostic tests. TOFHLA takes longer to administer, although a short version can be completed in approximately 12 minutes. (Columbia University, n.d.)

The third health literacy assessment scale in current use was jointly developed by Canadian and American researchers to be applied to the IALSS dataset. The researchers selected a subset of IALSS test questions from the four skill domains, which they classified as relating to health literacy. Initial results of this analysis were published by the Canadian Council on Learning (CCL) in 2007 and a follow-up report is expected in February, 2008. CCL reports that “60% of adults in Canada lack the capacity to obtain, understand and act upon health information and services and to make appropriate health decisions on their own” (CCL, 2008). The health literacy analysis also found that 88% of people over age 65 lack the literacy skills needed to deal with health information (CCL, Summary Report on Learning, 2007). Immigrants, the unemployed, and allophones (people whose mother tongue was neither English nor French) also have much lower health literacy scores than average.

Health Literacy Research Gaps

Researcher Ilona Kickbusch (2001) has articulated a number of areas requiring further research:

- Separating education, general literacy and health literacy
- Understanding how these three factors interrelate
- Distinguishing what reinforcing mechanisms might be at work
- Finding measures that reflect health literacy in terms of knowledge and the capabilities to act, solve problems and evaluate circumstances.

In reviewing the existing research relevant to the Canadian context, the Expert Panel on Health Literacy noted a lack of systematic information about health literacy levels among Aboriginal peoples, newcomers, people with disabilities and people living in rural areas, as well as a lack of research on the impact of low health literacy on health costs and health outcomes (Rootman & Gordon-El-Bihbety, 2008).

Does Health Literacy Matter?

Despite the gaps in knowledge, it is widely recognized that our health systems have become increasingly complex while adult literacy skills are much lower than what has been widely assumed. Effectively accessing health services requires sophisticated skills from health care consumers.

Canadians aged 16 to 65 who rate their health as excellent or very good have the highest levels of proficiency in health literacy. People who rate their health as fair or poor have the lowest levels of proficiency. People with the lowest health literacy skills are more than three times as likely to report fair or poor health. (Murray et al., 2007)

A recent American study examined mortality rates of a group of 3,260 adults over age 56 in four metropolitan areas and found that those with inadequate and marginal health literacy levels had a 50% higher mortality rate over a five-year period than those with adequate skills. Low health literacy was the top predictor of mortality after smoking, and was a more powerful variable than both income and years of education (Baker, Wolf, Feinglass, Thompson, Gazmararian, & Huang, 2007).

It is widely recognized that Canada's shifting demographic profile is contributing to the increased demands on health services. As the population ages, so does the incidence of chronic disease. At age 65, 77% of men and 85% of women have at least one chronic condition (Schultz & Kopec, 2003). Canada's total medication expenditure in 2005 was an estimated \$24.8 billion (CIHI, 2005), but the human and financial costs of medication error can only be guessed at.

Current Challenges

Surveys conducted by CPHA and others have found a very low level of awareness about the scope and nature of health literacy barriers in Canada among health and public health sectors. This is compounded by a lack of information about interventions that are both effective and wanted by professionals and the public.

U.S. Research has also shown that a great deal of health information materials are poorly designed and written at levels that exceed the reading skills of the average high-school graduate. (Rudd, Kirsch & Yamamoto, 2004). A great deal remains to be done to make health materials clear and accessible. However, written material is only accessible to those with the skills, capacity and willingness to read it, and the information will only be acted upon if it is relevant to individuals.

Medical culture and language are frequently not understood by the public. Scientific methods, inconclusive research, complex health conditions and nuances like “risk” and “probability” often do not lend themselves to simple communication or plain language.

Next Steps

Research shows that societies gain on many levels when gaps in health outcomes, socio-economic status, education and literacy are reduced. Although there are many gaps in existing knowledge, improving health literacy by increasing literacy skills and by decreasing the demands of health systems can contribute to better outcomes and greater social equality in Canada.

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