

SHORT COMMUNICATION

The Action Network on Measuring Population and Organizational Health Literacy (M-POHL) A network under the umbrella of the WHO European Health Information Initiative (EHII)

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ABSTRACT

Health literacy (HL) comprises a set of personal competences but depends also on characteristics of health-care systems and services that enable or hinder the usage of adequate health information for health-related decisions. With increasing evidence for its importance in health, there is also a growing interest in measuring HL. The Action Network on Measuring Population and Organizational Health Literacy (M-POHL) was started in February 2018, with the main aim of adding value to individual countries' efforts in

measuring and improving HL. This aim is being pursued by conducting cross-national comparative surveys on population HL, by measuring the HL responsiveness of health-care systems and organizations, and by suggesting recommendations for evidence-informed policy and practice. This current article provides an overview of the developments around HL and its measurement in the WHO European Region, and introduces the aims, structure and activities of the M-POHL network.

Keywords: HEALTH LITERACY, ORGANIZATIONAL HEALTH LITERACY, M-POHL, EHII, WHO EUROPEAN REGION

BACKGROUND

M-POHL IN A NUTSHELL

Health literacy (HL) is increasingly on the political agendas of the WHO European Region Member States. The Action Network on Measuring Population and Organizational Health Literacy (M-POHL) was founded under the umbrella of the European Health Information Initiative (EHII) in February 2018 in order to add value to national efforts in improving HL.

As described in its Concept Note (1) and the Vienna Statement on the measurement of population and organizational HL in the WHO European Region (2), M-POHL aims to enhance HL in the Region by facilitating the exchange of experiences, ensuring the availability of high-quality and internationally comparative data for benchmarking on population HL, and the HL responsiveness of health-care systems and organizations (3), as well as by developing and suggesting recommendations for evidence-informed policy and targeted practice interventions. M-POHL

is unique in linking policy and research as countries typically participate with one research and one policy representative.

As of March 2019, the following countries had been involved in M-POHL: Austria, Belgium, Bulgaria, Czech Republic, Denmark, Germany (North Rhine-Westphalia region only), Greece, Ireland, Israel, Italy, Kazakhstan, Luxembourg, Moldova, Netherlands, Norway, Portugal, Poland, Russian Federation, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Turkey, and the United Kingdom.

HEALTH LITERACY – IMPORTANT FOR HEALTH

HL has long been a topic for academic, practice, and policy discourse and is increasingly recognized as a critical determinant, mediator and moderator of health. While early American publications on HL go back to the 1970s (4), the topic was barely reflected on in Europe until 2006 when Switzerland pioneered a national HL survey (5). This initial effort triggered

the first European comparative HL survey, the so-called HLS-EU survey (European Health Literacy Project (HLS-EU) 2009–2012; cofinanced by the European Commission's Health Programme (Grant 2007–2013)) (6), which accelerated the HL agenda of the participating countries and beyond.

The HLS-EU survey indicated that limited HL concerns large proportions of the study population, with measurements in the eight participating countries (Austria, Bulgaria, Germany (North Rhine-Westphalia region), Greece, Ireland, Netherlands, Poland, Spain) suggesting that between one and two thirds of the adult population are affected by limited, that is a problematic or an inadequate, HL. More measurement efforts in countries in Europe (7–17) and Asia (18–20) followed suit, with results indicating the same trend. Therefore, according to the HLS-EU Consortium's definition of HL, "the knowledge, motivation and competences to access, understand, appraise and apply health information in order to make judgments and take decisions in everyday life concerning health care, disease prevention and health promotion to maintain or improve quality of life throughout the course of life" (21), a substantial number of adults have problems in accessing, understanding, appraising and applying health-related information in managing their health, which evidently has multiple implications. As indicated by a range of studies, people with better HL take better health-conducive everyday decisions, for example in relation to exercise choices (22); they use more preventive and less acute health-care services (23); as patients, they are better able to communicate their health issues to health professionals and to understand explanations and treatment options. They can take a more active and competent role in the self-management of their conditions and have better clinical outcomes (23, 24). Health economists estimate that limited HL accounts for 3–5% of health-care expenditure (25).

It is of specific concern that some groups of chronically ill and older people – population groups that typically need frequent and continuous health-care interventions – have an even lower HL than the general population average (22, 26) and are therefore more vulnerable to reduced health-care outcomes (23). This reduced opportunity for optimal health outcomes and greater difficulties in getting the maximum benefit from the health care received, represents an important issue for all concerned. Furthermore, HL is clearly related to social gradient, so that those with higher levels of education and income typically show better HL, and those with lower levels are more strongly affected by the consequences of low HL (6, 22, 23, 27).

Originally, the focus of HL in the US was on screening and measuring the HL of patients to identify those who

needed specific attention. However, a more comprehensive understanding of HL has evolved over time. HL is now perceived as the interplay between personal abilities and the demands of systems and organizations upon the individual (28). In other words, being able to access, understand, appraise and apply health information not only depends on individual skills but equally, according to researchers such as Rima Rudd (29) or Ruth Parker (28), on the quality of health information and services, especially in the areas of supporting navigation and providing information. The providers of health-care services have to make sure that both the services and information provided are accessible, understandable, appraisable and applicable (30), thus ensuring a robust basis for sound decision-making by the patient or client.

In addition to measuring personal HL, developments have been made in the measuring of the responsibility of health-care systems or organizations for HL, which some call HL responsiveness (3) or organizational health literacy (31) (see section 2.3). Combining both population HL and HL responsiveness data allows not only the identification of which population groups need most support in enhancing their HL, but also the assessment of which barriers in health-care systems and organizations need to be overcome in order to enhance the navigation of, access to, and the understanding and usage of the services and information provided.

HEALTH LITERACY – IMPORTANT IN GLOBAL AND EUROPEAN STRATEGIES

Global leaders in public health are paying increasing attention to the potential of HL. In 2009, the United Nations Economic and Social Council (ECOSOC) recognized the concept of HL as an "important factor for ensuring significant health outcomes" (32) and called for action plans for its promotion. Within the European Region, WHO's publication *Health Literacy: The solid facts* (33) summarizes important evidence around the topic and highlights HL as a key dimension for implementing the WHO European strategy *Health 2020*, not least in relation to its potential for promoting empowerment and participation in communities and in health care (34).

At WHO's 9th Global Health Promotion conference in Shanghai, China (November 2016), HL was prominently featured, resulting in the Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development (35). The Declaration establishes the link between HL and the United Nations Sustainable Development Goals (SDGs) (36) and calls for the development, implementation and monitoring of intersectoral strategies at national and local levels for strengthening HL in all populations. Within the European

Region, Regional Director Zsuzanna Jakab defined HL as one of the enablers of implementing the Sustainable Development Goals during the 67th WHO Regional Committee for Europe meeting in Budapest in September 2017.

The Organisation for Economic Co-operation and Development (OECD) has also started to work on HL, drafting a fast track paper on how HL is currently addressed by OECD Member States (37), which was published in December 2018. Also in 2018, the executive board of the International Union of Health Promotion and Education ratified a position statement supporting HL policy, practice and research at a global level (38).

Specific attention has also been given to the potential of HL in reducing the prevalence and impact of non communicable diseases (NCDs), as is reflected in the Montevideo Roadmap 2018–2030 on NCDs as a Sustainable Development Priority (39).

HEALTH LITERACY – IMPORTANT FOR NATIONAL HEALTH POLICY IN A GROWING NUMBER OF COUNTRIES

The availability of internationally comparable data on HL – enabling benchmarking with other countries – considerably contributed to the triggering of national responses in terms of public health policy throughout the European Region. After the HLS-EU survey, additional countries initiated population specific HL surveys including Albania (7), Belgium (8), Czech Republic (9), Germany (whole country) (10), Hungary (11), Israel (12), Italy (13), Malta (14), Norway (15), Portugal (16), and Switzerland (17). Also, numerous countries began to take action on improving HL, for example, with specific national strategies, policies or action plans (for example, Germany), or by establishing HL alliances or platforms (for example, Austria, Denmark, Germany, Netherlands, Switzerland). A recent Health Evidence Network (HEN) report (published in September 2018) specifically investigating HL policies, identified 46 existing and/or developing HL policies at international, national and local levels in 19 Member States of the WHO European Region (representing 36% of all 53 Member States) (40).

Because of the relevance and impact of the data, following the example of the Health Behavior in School-Aged Children (HBSC) study (41), where multiple countries joined forces for international monitoring and benchmarking, researchers involved in the HLS-EU project started to lobby for the implementation of regular and internationally coordinated European HL surveys, which lead to the development of the M-POHL.

HISTORY AND CURRENT ACTIVITIES OF M-POHL

A SHORT HISTORY OF M-POHL

Following the HLS-EU project, the European Region's publication *Health Literacy: The solid facts* (33) both summarized suggestions for improving HL across sectors and policy areas and called for regular comparative HL surveys in Europe in as many countries as possible. Inspired by a letter from HLS-EU scientists to the ministers of health of Austria, Germany and Switzerland in 2016, the ministers of these countries, together with their colleagues from Luxemburg and Liechtenstein (Quintet countries) jointly committed themselves to support the establishment of regular HL surveys in Europe. They implemented a working group to further explore the best way forward and came up with the idea of an action network under the umbrella of the WHO European Region, which received strong support from the EHII. The inaugural meeting of the resulting M-POHL network took place in Vienna, Austria, in February 2018, followed by a second network meeting in Berne, Switzerland, in August 2018. The 68th meeting of the WHO Regional Committee for Europe, that took place in September 2018 in Rome, Italy, hosted a technical briefing on HL measurement in the Region. Throughout the meeting, Member States repeatedly stated the need for HL measurements, such as the inclusion of HL as a progress indicator for Health 2020, and reinforced the importance of HL in almost all sessions of the Regional Committee.

HLS₁₉ – M-POHL'S FIRST PROJECT

M-POHL has been launching specific projects to reach its targets. Its first project, the HL Population Survey 2019/20 (abbreviated as HLS₁₉), will be the second comparative European HL survey and will pave the grounds towards regular European HL surveys. National samples of HL data will be collected based on a joint study protocol to ensure reliability and comparability for the cross-national analysis and benchmarking between participating Member States. The underlying model, definition and instrument of measuring and analysing HL builds on the integrated, comprehensive, multidimensional HLS-EU model (22, 26, 42).

While the focus of the study will be on population HL, the structure and type of questions, which follow the pattern developed for the HLS-EU survey (“how easy / difficult is it for you to ...”) (42), will also enable the identification of specific areas where improvements in systems or organizational HL responsiveness are needed.

By addressing specific research questions on determinants and consequences of different HL levels, domains and aspects that

will be captured in the survey tool, the study will contribute to further developing the HL knowledge base.

To ensure international comparability while also allowing for some leeway to cover specific interests of some participating countries, the HLS₁₉ survey instrument will be structured into three components:

1. HLS₁₉ core: mandatory questions that each participating country must include.
2. HLS₁₉ optional packages: questions on specific topic areas (such as digital HL, HL for communication and navigation in health-care services) from which participating countries can choose.
3. National add-ons: country-specific questions on topics of importance for national policy, research and practice.

At the time of submitting this article, the preparation of the survey instrument is ongoing. It will be made available in spring 2019. The data collection period for HLS₁₉ is envisaged to occur between the end of 2019 and spring 2020, and a comparative report will be available in 2021. Based on the results, suggestions for evidence-informed policy and practice will be developed and disseminated to relevant stakeholders within the European Region.

M-POHL'S SECOND FOCUS: HEALTH-CARE SYSTEMS AND ORGANIZATIONS' HL RESPONSIVENESS

Interventions of an educational nature that specifically address either individuals or groups of individuals are certainly important for some groups of the population and crucial for people living with NCDs/chronic diseases. However, due to the sheer number of those affected by low levels of HL and the limited capacities of health-care systems, it is often unrealistic to reach all those in need of support by personal interventions alone. So, in order to address larger groups of the population, interventions to improve the HL responsiveness of health-care systems and organizations are vital. To enable people to take good everyday health-related decisions and to determine the adequate usage of preventive care and treatment options, information in relation to health promotion, disease prevention and treatment needs to be:

- easily accessible, for example, via public health portals that provide trustworthy information;
- easily understandable. Information that is provided in leaflets, videos, apps or other sources needs to be provided

in easy-to-understand language, in the languages of the relevant target groups, and in culturally adequate forms. In personal communication, health promoters and health-care providers should use everyday language, offer interpretation services if needed, and encourage patients or clients to ask questions;

- easily appraisable. The source of information and conflicts of interest, if any, must be provided, so that individuals can assess the origins and trustworthiness of the information. In addition information should cover both the potential benefits and risks of treatment options or of specific services;
- actionable. It is important to provide support to patients or clients in transferring the information into personal decisions and actions – for example, if a person is advised to eat healthily, concrete options on how to do so should be provided.

To achieve all of this, health-care systems and organizations have to adapt the way that they provide orientation and information, and in order to support them in becoming more HL responsive, M-POHL aims to collect data and enable benchmarking at the health system and organization level. M-POHL has taken the Ten Attributes of Health Literate Organizations (23) and subsequent operationalizations of the concept, such as the Vienna Concept of Health Literate Health Care Organization (30), and the Organizational HL Responsiveness (Org-HLR) Framework (3), as starting points.

AN INVITATION FOR PARTICIPATION

M-POHL is open to all Member States of the WHO European Region. Countries typically participate with one policy and one research representative so that both perspectives can work together in improving HL. The M-POHL assembly convenes twice annually to discuss progress and to jointly decide on next steps. Participation in M-POHL is voluntary and without payment.

M-POHL's first project, HLS₁₉, is open for all countries from the WHO European Region that can meet the requirements of national participation, notably having sufficient funding and being able to meet the timeline of the survey, that is, to collect national data between November 2019 and March 2020.

Further information about M-POHL and HLS₁₉ is available on M-POHL's website (<http://m-pohl.net>).

CONCLUSIONS

HL has been increasingly recognized as relevant for health and health-care outcomes. Data from HL surveys provide evidence that huge proportions of populations in many countries are affected by limited HL. In order to improve chances for better health in their respective populations, more and more countries are becoming active in addressing HL. Since HL is not only determined by the ability of individuals within a population but also by the responsiveness of health-care systems and services, policy interventions and practice are more likely to be effective if they are not limited to personal interventions but seek to improve the quality of navigation support, information and communication within health-care systems and services.

M-POHL will continue to provide support to countries in the European Region in improving HL by providing high quality, internationally comparative data on population HL as well as data on health-care responsiveness, and by developing suggestions for policy and practice.

Acknowledgements: Heartfelt thanks to our colleagues from the M-POHL network who provided valuable feedback in the writing of this article: Eva-Maria Berens (Germany), Hanne Finbraten (Norway), Simona Giampaoli (Italy), Diane Levin Zamir (Israel), Christos Lionis, Georgios Koulterakis, Elena Petelos (all Greece), Gillian Rowlands (UK), Doris Schaeffer (Germany), Kristine Sørensen (Denmark).

Source of Funding: None.

Conflict of interest: None declared.

Disclaimer: The authors alone are responsible for the views expressed in this publication and they do not necessarily represent the decisions or policies of the World Health Organization.

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