Health Literacy

Background

The Australian Medical Students’ Association (AMSA) is the peak representative body of Australia’s 17,000 medical students. AMSA believes that the best attainable health is a right of all communities. Therefore, AMSA advocates for issues that affect health outcomes and the implementation of evidence-based strategies that contribute to improving health outcomes in every community.

Health literacy is defined as the extent to which an individual can access and comprehend information that pertains to understanding their own health, operating within the healthcare system, and making healthcare decisions.[1,2] Health literacy can be examined at two levels, at the individual health literacy capacity level, and the environment supporting the individual.[3] This includes but is not limited to infrastructure, policies, and published materials that impact the individual’s health literacy.[3]

Professional opinion on current Australian health literacy policy is divided. Some report a robust process of policy development while others describe these efforts as lacking.[4] Evidence supports that improved health literacy promotes behaviours that enhance health.[5,6] Beyond this, health literacy skills promote patient understanding, therefore improving patient autonomy and participation in decision making processes, whilst also supporting fully-informed consent.[5]

Measuring Health Literacy

Currently, most health literacy measurement tools focus on individual health literacy, and are designed for use in clinical settings.[4] Australia assesses population-wide health literacy with the Australian Literacy and Life Skills (ALLS) survey, the most recent of which was conducted in 2006.[7] It has been acknowledged that none of the currently available tools are full representations of an individual’s degree of health literacy.[8] However, new tools are being developed, such as the Health Literacy Questionnaire (HLQ), that better reflect health literacy, taking social and environmental contexts into account.[8,9]

Australian Health Literacy - How Do We Measure Up?

Low health literacy is common in Australia. The 2006 ALLS found 60% of adults to be performing at the lowest levels of health literacy when assessed for prose literacy, document literacy, numeracy and problem solving.[7]

Determinants of Health Literacy

Lower-performing groups report difficulties actively engaging with and navigating the healthcare system, finding or understanding health information and in having adequate health-related social support.

Demographics

Demographic determinants of health literacy include age, ethnicity and gender.[10] Rates of adequate or better health literacy decrease in Australia after the 20 – 49 age bracket.[11] This decline may be associated with reduced cognitive reserve, longer time since formal education and lower levels of formal education attainment current older generation.[11] Lower levels of computer access and skills among elderly people may also contribute to reduced health literacy in an era where health information most prominent online.[12] Australians born overseas or whose first language is not English have lower health literacy than Australians born in Australia or people who spoke English as a mother tongue.[11]

Evidence suggests that ‘one size fits all’ healthcare services may disadvantage these subgroups.[13] Current health literacy measurement tools may be stigmatising for culturally and linguistically diverse populations, and are biased towards those with higher English
Currently available studies of migrant health literacy are often insufficiently powered, and are not generalisable across demographic subgroups such as age and gender.[9]

**Individual competencies and health status**

Education level may be the most important factor influencing health literacy, with an increased level of education correlating with increased health literacy.[11,15] Innate cognitive and sensory abilities also determine competencies and thus health literacy.[10] Lower rates of health literacy are evident amongst people with a disability, and as previously mentioned, rates decline amongst the elderly.[2] When physically ill or anxious within a healthcare setting, individuals who otherwise have adequate health literacy may find it challenging to interpret health information.[16]

**Socioeconomic factors**

Socioeconomic factors such as occupation, employment status, income, and income discrepancy influence health literacy.[10] Health literacy skills increase with income level, which is also informed by education status. 63% of the high-income bracket in Australia has adequate or better skills as compared to 43% of the middle-income bracket and 26% of those with low income.[11] Within income brackets, higher levels of education are associated with greater health literacy.[11]

**Healthcare systems**

Health literate healthcare organisations enable patients to navigate, comprehend and utilise health information to increase patient participation in care.[17] Complexity of health services and information, such as barriers to successful wayfinding in healthcare facilities,[18] are major factors influencing the efficacy of the health literacy environment.[19]

**Policy**

Government policies and programs addressing health literacy, health education and health promotion, social supports and networks are determinants of health literacy.[8] Surrogate measures such as expenditure on social protection correlate strongly with health literacy scores.[10]

**Aboriginal and Torres Strait Islander Peoples Health Literacy**

Australian Aboriginal and Torres Strait Islander people are significantly disadvantaged despite government initiatives like ‘Close the Gap’, which aim to improve health and education outcomes. Addressing language barriers and cultural differences is a key step to improving Indigenous peoples’ health literacy.

Cultural differences pose considerable challenges as health literacy is dependent on receiving comprehensible information in a culturally acceptable manner.[20] There are a number of health education methods specific to the Indigenous community which effectively accomplish this (see Appendix A). These health education methods are effective because they integrate new health information into the already well-established frameworks of local Indigenous concepts of health and wellness, and place an importance on integrating Indigenous health knowledge systems into the way physicians talk about western medicine with Indigenous patients.[21,22] Sharing new health information with Elders and the Indigenous community via storytelling in the local language is another factor that makes these strategies effective. Involving the specific Indigenous community in the development of health information is essential for overcoming cultural and linguistic barriers that Indigenous people experience in a western-oriented healthcare system.[21,22] Studies highlight that despite-effective verbal communication between health workers and Aboriginal or Torres Strait Islander patients, differences in worldview can significantly affect understanding.[21,22] Overcoming these barriers through appropriate cultural training with effective strategies for information delivery are key to improving health outcomes.

Most health information in Australia is conveyed in English, however only 85% of Indigenous respondents reported the ability to speak English well or very well in the 2016 census.[23,24] Further, Indigenous children consistently underperform on tests of literacy and numeracy compared to their non-Indigenous peers.[25] In addition to improving literacy, there is a need to incorporate effective resources and translation services to assist in improving health literacy. A 2017 study found that Indigenous translation services in the Northern Territory were vastly underutilised with booking complexities and inadequate training and information being cited as key barriers to use.[25]
Mental Health Literacy
Mental health literacy (MHL) refers to “knowledge and beliefs about mental disorders which aid their recognition, management or prevention”. Having poor MHL may lengthen the duration of an untreated mental health condition.

Proper distribution of mental illness information is critical to successfully implementing mental health promotion initiatives. Past surveys reveal that 65% of those in the general population and 56% with mental illness did not receive mental illness information in the past year. Those who accessed mental health services were more likely to receive helpful mental illness information than those who did not. Preparation of targeted messages (message tailoring) has been found to be an effective strategy in health communication.

Certain demographic subgroups have worse MHL than others, possibly due to cultural factors such as perceptions of mental illness and stigma, and socio-contextual factors such as differences in healthcare systems.

The Role of the Internet
While electronic health literacy is gaining prominence in healthcare and influencing patient’s decision making processes, there is substantial variability in the quality of information available. Evidence supports that electronic resources offer a powerful adjunct to the conventional doctor-patient consultation, particularly in the mental health sphere where online programs have been developed to promote psychological well-being. As some studies suggest that approximately 60% of patients overestimate the credibility and reliability of electronic information, there is growing concern that patient healthcare is being compromised by inaccurate web-based health information. Furthermore, empowerment as a result of information obtained from the Internet sources, without properly communicating with a healthcare provider, is associated with increased rates of noncompliance. Although reliable and evidence based electronic information is available, there is a need to improve patient awareness and ensure information is available across a broad range of modalities. People also need to be empowered with the skills to assess the credibility of their sources of health information online, and understand the basis of evidence-based medical information, in order to make fully informed decisions about their health behaviours and healthcare.

Vaccinations, Health Misinformation, and Health Literacy in Australia

With the advent of fast media, health misinformation can be quickly spread purposely or inadvertently throughout society by a variety of actors. Once disseminated there are substantial difficulties in correcting health misinformation. Several studies have attempted to understand the reasons for individual’s persisting to believe health misinformation, identifying individual cognitive factors, difficulty reaching target audiences, and societal mechanisms that enable health misinformation to perpetuate. At the individual level, health misinformation is likely to be perpetuated if it is congruent and coherent with an individual’s prior beliefs, seemingly credible, repeated, and agreed upon by an individual’s social group. These elements are influenced by an individual’s worldview and their level of skepticism.

According to WHO, vaccine hesitancy is currently a top threat to global health, recently contributing to a recent 30% increase in measles cases worldwide. In Australia, despite the fact that children’s vaccination rates are above 90%, they have not yet reached the Department of Health’s aspirational target of 95%. It is important to note that vaccine rejection is not the only reason that parents choose to forego vaccinations - other barriers exist, including logistical difficulties, missed opportunities, and lack of access to health services. Vaccination objection, which has been observed in all states of Australia, has been attributed to cultural and psychosocial orientations associated with unwillingness to engage with scientific evidence. Interventions that aim to increase individual and population-wide understanding of and trust in evidence-based medicine may increase vaccine compliance.

Health Literacy Interventions
Interventions to improve health literacy have been implemented in various settings in Australia and worldwide (see Appendix A). One paper identified 15 programs across the world that had significant efficacy in improving health literacy of patients. These programs often featured intensive individual support programs (delivered via telephone or group support settings).
Programs to improve patient confidence in asking questions of their healthcare providers also proved fruitful in improving health literacy outcomes.[44]

Numerous experts question the rigour of studies aiming to establish the efficacy of health literacy programs.[45,46] One study found that a third of all randomised control trials researching the efficacy of health literacy interventions lacked substantial attrition and was thus at risk of failing to provide effective power for the study. It also found that trials typically looked at short term knowledge improvement and not patient oriented outcomes such as clinical improvement.[46]

Position Statement

AMSA believes that:
1. Health literacy should be promoted nationally to all relevant stakeholders, from individuals to their healthcare environments;
2. Education level and health education are crucial factors in improving health literacy, and thereby improving health outcomes of Australians;
3. Health information should be delivered in a way that is appropriate and understandable for the target audience;
   a. Cultural and linguistic backgrounds should be key considerations in the delivery of health information, as it presents a barrier to health literacy, particularly in Aboriginal and Torres Strait Islander peoples, migrants, and culturally and linguistically diverse populations;
   b. Complexity of health information should be appropriate for target audiences;
4. Health misinformation is a significant issue in Australia which needs to be actively addressed;
5. The evidence base and methods of acquiring health literacy statistics are in need of improvement, as are methods of improving health literacy in Australia.

Policy

AMSA calls upon:

1. The Australian Commonwealth, State, Territory, and Local Governments to:
   a. Acknowledge that improving health literacy will require an intersectional approach, with collaboration from all levels of government across many government portfolios.
   b. Initiate and support dialogue and collaboration between the health and education sectors.
   c. Finance and encourage further research into:
      i. Improving the quality of health literacy measurement tools in order to improve the accuracy of data.
      ii. Strategies to increase access to education for all Australians.
      iii. Improving the quality and effectiveness of health literacy public health programmes, with a particular focus on population demographics with lower rates of health literacy, including but not limited to - low socioeconomic, older, lower access to education, regional/rural/remote, Aboriginal and Torres Strait Islander people, and other culturally and linguistically diverse populations.
      iv. Aboriginal and Torres Strait Islander peoples education outcomes, and development of further culturally and linguistically appropriate strategies to improve education outcomes.
      v. How internet and mobile technology impacts dissemination, comprehension, and understanding of the credibility of health information.
      vi. Effective methods to combat health misinformation, both on an individual patient interaction level and on a public health campaign level.
d. Finance innovative evidence-based initiatives that aim to increase access to education for all Australians, because attained level of education is significantly linked with health literacy level;
   i. Finance culturally-appropriate initiatives that work towards Closing the Gap in Aboriginal and Torres Strait Islander peoples education outcomes.
   ii. Finance the education sector with additional resources to support refugee, migrant, and other culturally and linguistically diverse students in improving English literacy skills to be on par with Australians who have English as their mother tongue, because this is significantly linked with improved health literacy.
   iii. Develop and finance initiatives that support lower socioeconomic people accessing higher levels of education.

e. Finance, encourage development of, and implement health promotion strategies that incorporate accessible education on preventative health.

f. Finance illness-specific patient and family support groups that provide plain language health information.

g. Specifically finance public health campaigns that target the importance of vaccines, herd immunity in prevention of disease, and dispelling common health misinformation associated with vaccine hesitancy.

2. The Australian Government Department of Education and Training working in conjunction with the Department of Health to:
   a. Increase quality and quantity of health information delivered to students at all levels in early childhood, primary, and secondary schooling in an age-appropriate mode of delivery.
   b. Specifically educate primary and secondary school students, in an age-appropriate manner, about;
      i. The credible health resources available to them, for example government websites.
      ii. Skills on how to appraise the quality of online health information.
      iii. Navigating the structure of the Australian healthcare system, and seeking available healthcare (for example, mental healthcare services).
      iv. Vaccines, how vaccines work and interact with the immune system to prevent disease, and dispel common health misinformation associated with vaccines.

3. Hospitals, health districts, healthcare providers, and private sector companies to:
   a. Provide meaningful and accessible information regarding specific diseases, health rights, and healthcare procedures;
      i. Provide culturally and linguistically appropriate healthcare information for Aboriginal and Torres Strait Islander people and migrant populations.
      ii. Partner with local Aboriginal Community Controlled Health Services in production of health information for local Indigenous people that is culturally and linguistically appropriate.
      iii. Disseminate healthcare information to elderly patients, who are at higher risk of low health literacy.
      iv. Utilise social media and the internet effectively through user-targeted public health campaigns to distribute relevant evidence-based health information, and perpetuate awareness about quality evidence-based health resources.
   b. Make interpreter services readily available for patients whose primary language is not English.
c. Educate their staff and medical students on clinical placement about interpreter services and how to access them, including Aboriginal and Torres Strait Islander language translation services.

d. Disseminate information on pre-existing translation services, for example the Translating and Interpreting Phone Service.

e. Make support persons and online methods of information available to assist patients for informed decision making and guidance through the healthcare system.

f. Support residential aged care homes in providing digital literacy education to residents as a means of increasing access to health information.

g. Generate and distribute locally relevant information about vaccines, how vaccines work and interact with the immune system to prevent disease, and dispel common health misinformation associated with vaccines.

4. Australian Specialist Medical Colleges to:

a. Provide speciality-appropriate training and education regarding the clear, effective, and culturally accessible delivery of health information.

b. Advocate for the improvement of health literacy in their respective specialist areas.

c. Utilise social media and the internet effectively through user-targeted public health campaigns to distribute relevant evidence-based health information.

d. Develop resources (for example pamphlets, brochures, online materials) on medical conditions within their speciality for patients in multiple languages, focusing on common non-English languages, including but not limited to Mandarin, Arabic, Cantonese, Vietnamese, Italian, local Indigenous languages, and Braille.

e. Disseminate these health resources, ensuring they are free for clinicians and medical students to access and provide to patients.

5. Medical schools, universities, and educational institutions to:

a. Provide education to medical students regarding:

   i. The clear, effective, and culturally accessible delivery of health information to patients.

   ii. Recognising when there are significant cultural or linguistic barriers to the patient's understanding of the health information being delivered, and strategies on how to effectively overcome these barriers (for example, accessing translation services or seeking support from a local Aboriginal health worker).

   iii. Clear and effective explanation skills to patients about evidence based medicine, the importance of scientific rigor of health information, and how to discern credible health information from health misinformation.

   iv. Methods to respectfully and effectively educate patients with vaccine hesitancy and dispel health misinformation with evidence-based health information.

b. Recognise 'effective explanation of health information’ as a fundamental assessable clinical skill.

c. Direct research on the status of health literacy in Australia.

d. Partner with local communities to develop culturally and linguistically appropriate health information, for example at medical student clinical placement sites.

e. Encourage and support the completion of some form of formal mental health training by students and staff.

f. Increase access to relevant health literacy information and services for medical students, for example information on accessing mental healthcare, as part of their duty of care to their students.
6. AMSA Projects and Special Interest Groups to:
   a. Coordinate activities relevant to improving health literacy in their respective areas, with both nationwide activities and activities run locally by project representatives.
   b. Collaborate with AMSA Medical Education in creation of resources (for example, short-courses) which aim to increase capacity of Australian medical students to communicate complex health information to patients in their respective areas.
   c. Create AMSA Medical Education resources specifically on how to respectfully and effectively educate vaccine hesitant patients about how vaccines work and their importance, and dispel health misinformation with evidence-based health information.

7. Student Unions, Medical Student Societies, and Student Global Health Groups to:
   a. Support and facilitate grassroots action from their membership in their local communities to support health literacy skills, in both student and the wider local population;
      i. Connect medical students with local non-government organisations working towards increasing health literacy in their community, especially regarding to non-government organisations that target demographics at risk for lower health literacy, as listed in 1ciii.
      ii. Partner with local non-government organisations, education services, and multicultural support groups to develop and facilitate activities that engage their medical student membership base in targeted health promotions.
   b. Take grassroots action in their local communities to facilitate student membership in activities that increase access to education overall, especially for populations such as Aboriginal and Torres Strait Islander peoples and refugee populations.

References


Policy Details

Name: Health Literacy (2019)

Category: Category: F - Public Health in Australia

History:

Adopted, Council 1, 2019

Kira Muller (Co-lead Author), Davina Daudu (Co-lead Author), Vandita Mattoo, Connie Jiang, Rebecca Wardell, Jacqueline Bredhauer, Rachel Yanner, Daniel Zou (Policy Officer)

Appendix

A. Examples of successful interventions to improve health literacy in various settings

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<tr>
<th>Type of intervention</th>
<th>Example</th>
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<tbody>
<tr>
<td>Physical Health</td>
<td>‘Sport in School’</td>
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<td>Victorian state schools currently require years 4-6 students to meet a minimum of 3 hours per week of physical education.[47] School programs vary across states, but studies suggest that programs often do not meet recommended daily exercise targets or build physical skills to an appropriate level to encourage long term adoption of physical activity.[48,49]</td>
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<td>School Programs</td>
<td>‘Healthy Harold’ Program</td>
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<td>The program uses puppetry, storytelling and interactive educational techniques to build children’s health literacy around drug and alcohol use as well as fostering a healthy lifestyle.</td>
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<td>In a 2017 evidence base report, good efficacy of the program was demonstrated. For example, in a pre-survey 78.8% of students said they would never smoke. This increased after the session to 85.2%. Over 90% of students additionally said they believed they were less likely to smoke because of what they had learned in the session.[50]</td>
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<td>Mass Media</td>
<td>Patient Information Leaflets</td>
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<td>Patient information leaflets have been shown to improve patient knowledge and satisfaction. Their strongest effect is on acute conditions where patient information leaflets improve short term compliance with treatment. Their role in chronic diseases, invasive diseases and screening is less clear - with variations depending on the context of the situation.[51]</td>
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<td>Vaccination</td>
<td>Social Marketing Campaigns</td>
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<td>The social marketing campaign ‘Take Control! Immunise’ in the United States used billboard, flyers and other marketing tools like promotional pens and backpacks to increase awareness.</td>
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<td>The campaign had good reach with 85% of respondents in a study stating that they remembered the campaign. Nearly half that remember seeing the campaign stated that it triggered them to make enquiries about updating their children’s immunisation status.[52]</td>
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<th>Culturally sensitive interventions specific to Indigenous Australians</th>
<th>‘Discovery Intervention’</th>
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<td>One way to address cultural barriers when communicating with Indigenous Australians is through discovery education, which is a way to integrate new information into the cultural knowledge of individuals, within a community. Aboriginal and non-Aboriginal educators will produce relevant stories about a health-related topic in the local language to share with Elders and the community. This form of community health education is shown to be well-received and effective.[21,22]</td>
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<tr>
<th>Culturally sensitive interventions specific to culturally and linguistically diverse populations</th>
<th>‘Information on Diabetes in Greek’</th>
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<td>The Royal District Nursing Service collaborated with the Australian Greek Welfare Society and the Aspin group to produce a talking book that educated members of the Greek community about diabetes.[14] The resource contained case studies, role plays and information sheets, with all information provided in Greek and optional English subtitles.[14] Centre for Cultural Diversity and Ageing communication tools</td>
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<td>The Victorian Centre for Cultural Diversity and Ageing has created various multilingual tools for its aged care centre.[14] These include bilingual communication cards and a glossary of aged care terminology that have been translated into 19 languages.[14]</td>
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| Internet interventions | Studies demonstrate that successful internet-based interventions, such as MoodGYM and social network games, can improve MHL and symptomatology.[53–55] Generally, effective web-based interventions include active ingredients which involve a structured program that promotes interactivity and experiential learning, as opposed to a didactic approach. Information should also be evidence-based and target specific populations.[36] |

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<tr>
<th>Older people</th>
<th>‘Literacy-sensitive Self-Care Intervention for Patients with Heart Failure’</th>
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<td>Heart failure is a complex condition that is a prevalent cause of hospitalisation among over 65’s. High levels of understanding and competency of self-management are necessary to prevent acute exacerbations. A program that delivers intensive, literacy-appropriate instructions for heart failure management tailored to individual patients’ needs has been found to reduce the risk of hospitalisations or death.[56]</td>
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<th>Rural Communities</th>
<th>Oral Health in Rural Communities</th>
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<td>Indigenous Australians have poorer oral health than non-Indigenous counterparts, particularly those in non-metropolitan settings. This is</td>
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associated with poorer oral health practices, such as lower rates of adequate tooth-brushing and dental visits, and poor outcomes including higher rates of toothaches and tooth loss. A community based oral health literacy intervention in Port Augusta, South Australia delivered a series of five workshops, consisting of group discussions, hands-on practical activities, role plays and interactive displays, supervised by Indigenous project officers, over a 12-month period. The focus of this functional, context-specific intervention was to improve patient confidence in accessing dental care and provide culturally sensitive education on dental disease processes.[57]

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<th>Mental Health</th>
<th>School Based Interventions</th>
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<td>The mental health for everyone’ program was a program run in schools to increase understanding around understanding of mental health, and how to access mental health services. Results from the study showed that while there was an increase in understanding of the role of primary health for seeking help, students’ that initially had stigmatised views around mental health had limited growth. This suggests prejudice may need to be specifically addressed as a part of expanding health literacy.[58]</td>
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