

Health literacy: Challenges for patients and for health professionals

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Health Literacy



- Not a new concept ...
 - To be ***literate*** = being “knowledgeable or educated in a particular field or fields”
 - Increased attention since the mid 20th century
 - The ability to identify, understand, interpret, create, communicate, compute and use printed and written materials associated with varying contexts (UNESCO)
 - Enlarged to a range of competences considered important to function in the 21st century
 - Application to the health sector since the 1970s
- An expanding concept
 - Expanding body of ***scientific research***
 - Expanding ***scope and meaning***
 - Expanding ***political interest***

Expanding research on Health Literacy



- First research articles on health literacy published in the late 1970s
- More than 8500 publications on health literacy listed today
 - 70% published in the last 5 years
 - > 1000 new publications per year

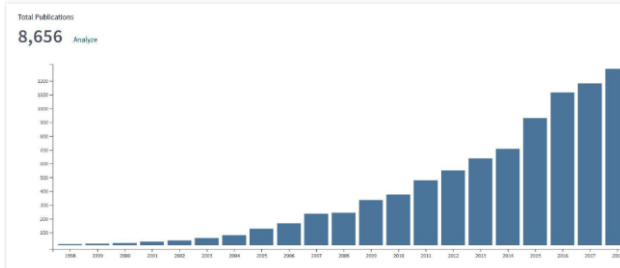


Chart from Thomson-Reuters *Web of Science* database. Accessed January 2019

Expanding scope and meaning of health literacy

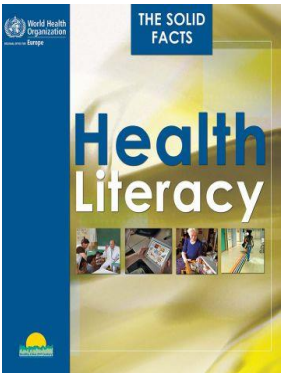


- From medical to public health literacy
 - Initial emphasis on individual competencies in the context of health care («**medical health literacy**»)
 - Since the last decade enlarged to a broad set of competences that are also relevant for disease prevention and health promotion («**public health literacy**»)



- From purely functional to interactive and critical health literacy
 - **Functional HL**: the ability to handle words and numbers in a medical context
 - **Interactive** and **critical HL**: information seeking, decision making, problem solving, critical thinking, communication, social, personal, and cognitive skills that are necessary to function in the health system

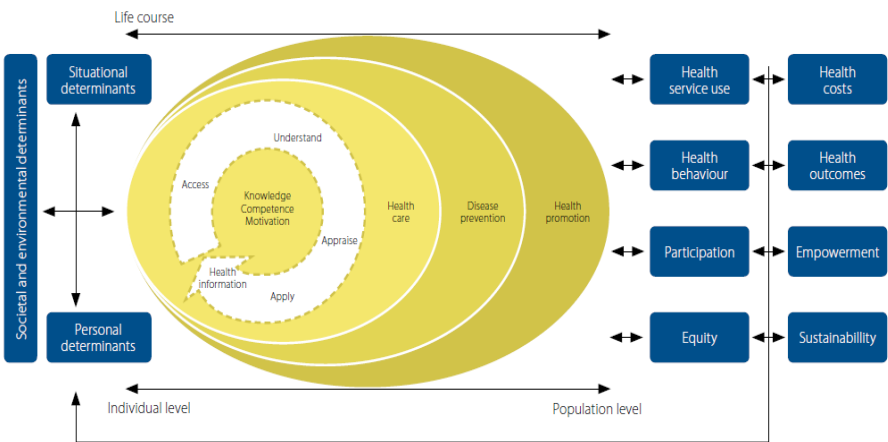
A multidimensional concept



« A person's knowledge, motivation and competences to access, understand, appraise, and apply health information in order to make judgments and take decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life course»

Sørensen et al., Health literacy and public health: A systematic review and integration of definitions and models. *BMC Public Health*. 2012;12:80

A Conceptual model of Health Literacy



Sørensen et al., Health literacy and public health: A systematic review and integration of definitions and models. *BMC Public Health*. 2012;12:80

Health competencies

Domain	Type of information	Examples of skills and competencies
Disease care and management	Information about medical subjects Medical history forms, information brochures, medication leaflets	Recognize symptoms, follow medical instructions, calculate dosage of prescribed medicine
Functioning in the health care system	Information about the health care system Medical insurance forms, information about rights and responsibilities	Choice of a doctor or specialist, make an appointment, ask questions to health care professionals, take out medical insurance, complete medical insurance claims
Prevention and health protection	Information about health risks Health items in the media (TV, radio, newspapers, ...), information about screening, health check results, health warnings.	Estimate one's own health risks, decide on participation in screening or vaccination programs, understand health warnings on dangerous products
Health promotion	Information about health determinants Articles in newspapers and magazines, internet sites, brochures, books	Buying and preparing healthy food, engage in healthy physical activity, quit smoking, develop and maintain social contact, engage in community life

Growing recognition of the importance of Health Literacy



- **UN**
Considers HL important for the achievement of targets related to the Sustainable Development Goals



- **WHO**
 - Improving health literacy is one of the priorities in the strategy document for the European Region « Health 2020 »
 - HL was one of the three priorities of the 9GCHP (Shanghai, 2016)



- **EU**
 - HL in the « Health for Growth » programme (2014-2020)



- **National level**
 - Several countries around the globe recognize the importance of health literacy and put policies in place to address low HL

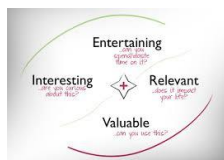
Rowlands et al. (2018) What is the evidence on existing policies and linked activities and their effectiveness for improving health literacy at national, regional and organizational levels in the WHO European Region?
Copenhagen: WHO Europe; 2018

Growing recognition of the importance of Health Literacy



- **Canada:** A Vision for a Health Literate Canada (2008)
Health Literacy Council of Canada
- **USA:** National Action Plan to Improve Health Literacy (2010)
- **Germany:** Nationales Gesundheitsziel, Gesundheitliche Kompetenz erhöhen (2011)
- **Scotland:** Health Literacy Action Plan NHS HealthScotland (2012)
- **Australia:** Communication and Health Literacy Action Plan (2013)
- **The Netherlands:** Report on Health Literacy (NIVEL, 2014)
- **Austria:** Gesundheitskompetenz der Bevölkerung stärken
- **Israel:** Objectives on health literacy included in the National Developmental Goals 2020
- **Belgium:** Health literacy in the Governmental Declaration (2014)
- **Singapore:** Singapore Action Plan to Improve Health Literacy

Why the interest in Health Literacy?



Relevant



Modifiable



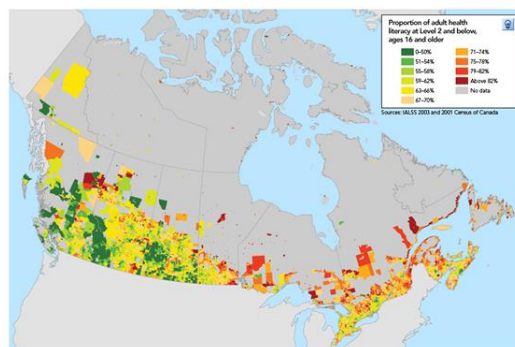
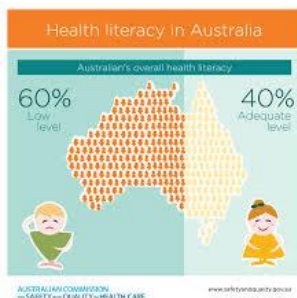
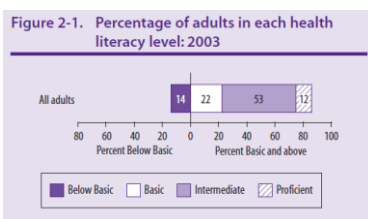
Measurable



Measuring Health Literacy

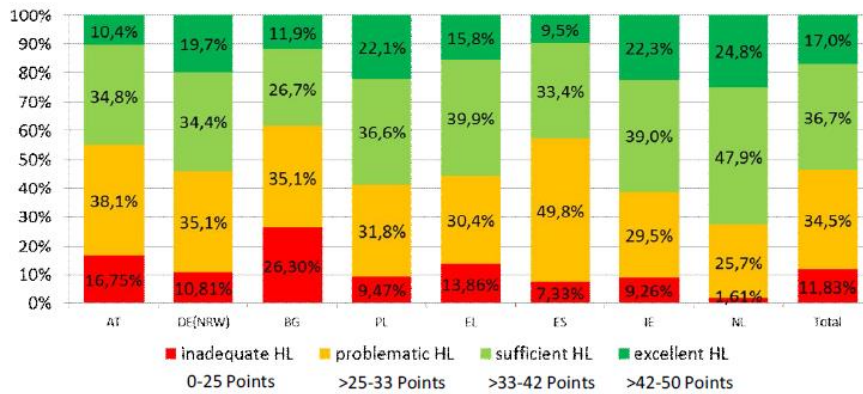
- A large range of measures available
 - >191 instruments listed in the **Health Literacy Tool Shed** <https://healthliteracy.bu.edu/>
- Important differences in terms of type, objective and target group
 - Objective versus subjective measures
 - Objective and target groups:
 - HL screening in a clinical context
 - Rapid Estimate of Adult Literacy in Medicine (**REALM**), Test of Functional Health Literacy (**TOFHLA**), Newest Vital Sign (**NVS**)
 - Population survey:
 - National Assessment of Adult Literacy survey (**NAAL**), Health Literacy Questionnaire
- European Health Literacy Survey **HLS•EU**
 - Concept validated tool of 47 self-report items measuring 12 sub-scales
 - Used to collect data on 8000 respondents in 8 EU countries
 - Used on a total of 10,024 respondents in 6 Asian countries (Indonesia, Kazakhstan, Malaysia, Myanmar, Taiwan, Vietnam)
 - Short forms of 16 and 6 items increasingly used (Belgium, France, Portugal, Italy, Sweden, ...)
 - Updated version soon to be introduced

Increasing availability of data on Health Literacy in populations



Health Literacy in Europe (HLS-EU, 2012)

Percentages of different levels of the general HL-Index in the 8 participating countries and the total sample of HLS-EU



Health literacy in Europe and Asia



Duong et al. (2013)

Importance of Health Literacy



- An outcome of health education
(as a strategy of health promotion)
- A determinant of the quality of health care
- A determinant of health outcomes and health care costs
- A mediator of the relationship between SES / education and health outcomes

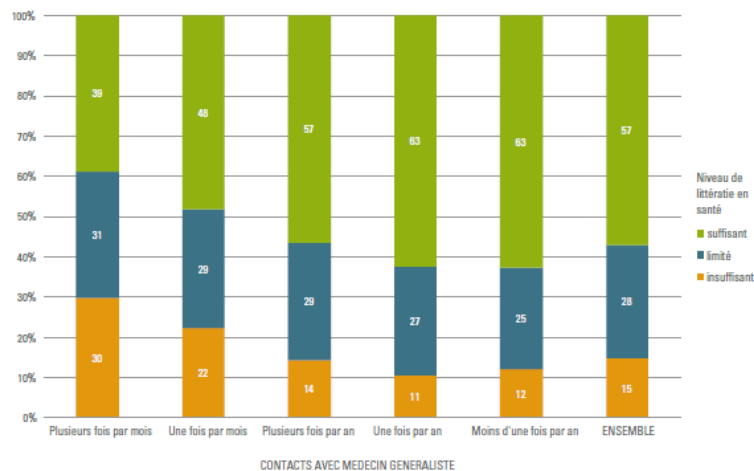
Health Literacy as a determinant of the quality of health care



People with low health literacy have difficulty to

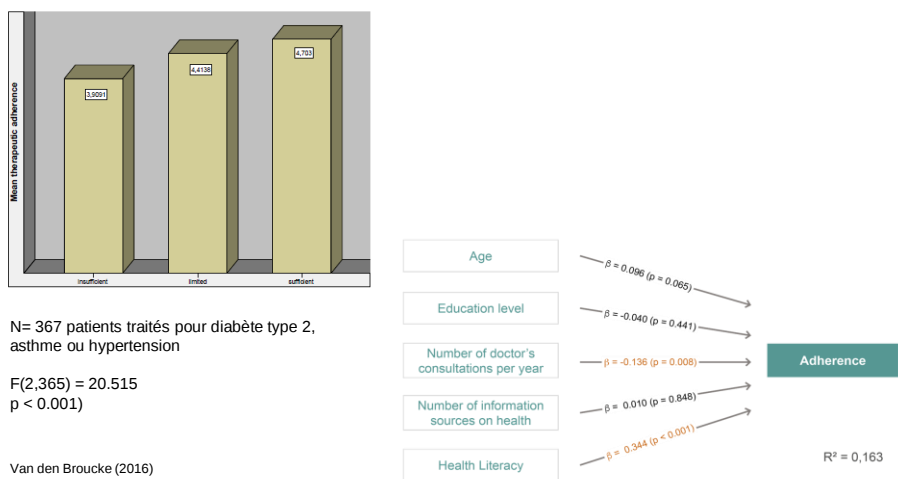
- understand information provided by health carers
- understand written health information
- find their way in the health care services
- find their way in health insurance
- take control over their own health

Health literacy and frequency of contact with General Practitioners



Avalosse et al. (2016)

Health literacy and therapeutic adherence



Health literacy as a determinant of health outcomes



- Outcomes of health care

People with low health literacy have

 - less self care
 - more chronic disease
 - 1,5 times higher mortality (Baker et al., Arch Int Med, 2007)
- Outcomes of prevention

People with low health literacy

 - have less healthy lifestyles
 - participate less in screening
- Costs of care

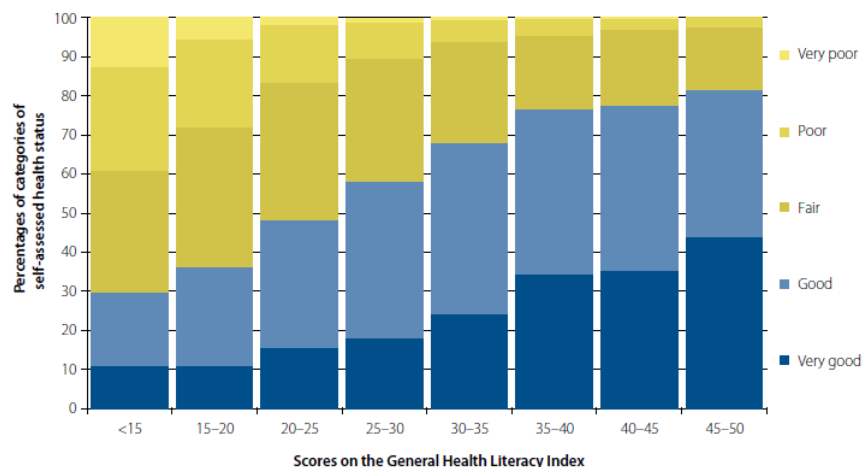
Health literacy and chronic disease self-management

Table 2. Outcomes of DSME for high and low health literate patients using repeated-measures MANOVA.

	Total (N = 366)		Low HL (N = 184)		High HL (N = 182)		<i>F</i> _{Time}	<i>F</i> _{HL}	<i>F</i> _{Interaction}
	T1	T2	T1	T2	T1	T2			
	<i>M</i> (SD)	<i>M</i> (SD)	<i>M</i> (SD)	<i>M</i> (SD)	<i>M</i> (SD)	<i>M</i> (SD)			
<i>Diabetes Health Literacy</i>									
Functional	2.80 (0.76)	2.75 (0.79)	2.57 (0.76)	2.60 (0.82)	3.03 (0.69)	2.90 (0.74)	2.03	28.16***	5.33*
Communicative	3.11 (0.74)	3.16 (0.63)	3.05 (0.74)	3.16 (0.64)	3.19 (0.73)	3.16 (0.63)	1.66	1.22	3.87*
Critical	2.96 (0.81)	2.99 (0.79)	2.86 (0.82)	2.91 (0.76)	3.06 (0.78)	3.07 (0.80)	0.38	6.66*	0.09
Combined ^a							1.16	11.70***	3.25*
<i>Behavioural outcomes</i>									
Diet	4.35 (1.51)	4.54 (1.36)	4.22 (1.52)	4.49 (1.33)	4.47 (1.48)	4.59 (1.39)	7.04**	1.72	0.93
Exercise	2.92 (2.29)	3.41 (2.30)	2.80 (2.21)	3.35 (2.22)	3.03 (2.36)	3.47 (2.39)	23.33***	0.65	0.25
Blood testing	2.92 (2.84)	3.27 (2.86)	2.92 (2.85)	3.21 (2.85)	2.92 (2.83)	3.32 (2.87)	8.70**	0.04	0.21
Foot care	3.63 (1.77)	4.17 (1.66)	3.46 (1.77)	4.07 (1.66)	3.80 (1.77)	4.26 (1.65)	37.21***	2.88	0.74
Combined ^a							15.42***	0.90	0.45
<i>Psychological and health outcomes</i>									
Problem perception	2.52 (1.09)	2.75 (1.08)	2.41 (1.10)	2.59 (1.13)	2.63 (1.08)	2.91 (1.01)	25.13***	6.74*	1.09
Coping	3.53 (0.65)	3.68 (0.67)	3.44 (0.65)	3.57 (0.67)	3.63 (0.63)	3.80 (0.64)	26.43***	11.72**	0.49
General health	3.14 (0.77)	3.31 (0.78)	3.06 (0.72)	3.26 (0.79)	3.23 (0.81)	3.36 (0.76)	23.72***	3.50*	1.09
Well-being ^c	2.38 (0.87)	2.42 (0.88)	2.22 (0.91)	2.36 (0.89)	2.59 (0.80)	2.63 (0.80)	3.14*	13.39***	0.81
Combined ^a							14.47***	3.89**	1.06

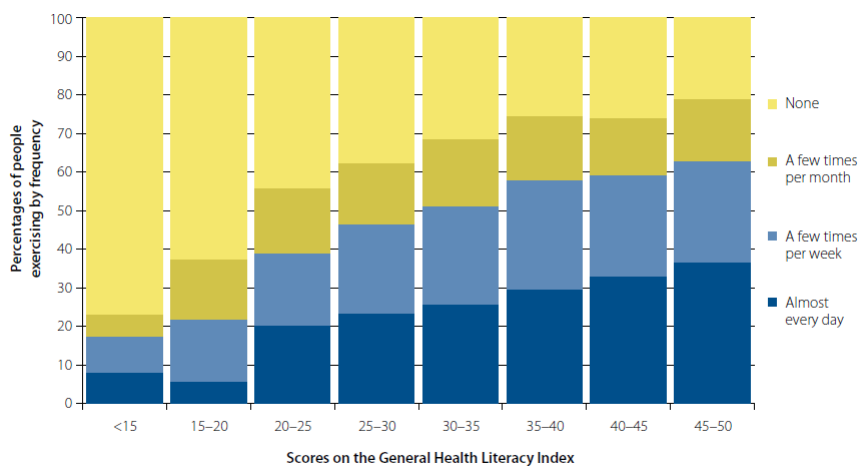
MANOVA: multivariate analysis of variance; HL: health literacy; M: mean; SD: standard deviation.
^aMultivariate outcome indicating whether there are significant differences regarding the combined dependent variables.
^bSignificant at *p* < .10.
^cThe well-being variable was not included in the multivariate model due to missing values (N=284) and was analysed separately using univariate test. The last multivariate outcome thus refers to the combination of problem perception, coping and perceived general health.
^{*}*p* < .05; ^{**}*p* < .01; ^{***}*p* < .001.

Health Literacy and perceived health



World Health Organization (2013). *Health literacy. The solid facts*. WHO Regional Office for Europe: Copenhagen.

Health Literacy and physical activity



World Health Organization (2013). *Health literacy. The solid facts*. WHO Regional Office for Europe: Copenhagen.

Health literacy and health care costs (Belgium)

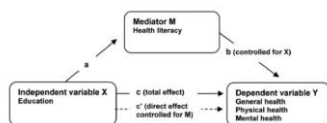
Costs related to the use of healthcare services		Logistic regression (users/non-users)				Regression for users†			
		β	SE	χ ²	OR	β	SE	χ ²	IRR
Costs of hospitalisations									
GH	Limited HL	-0.04	0.05	0.35	0.96	0.08	0.03	6.49*	1.08
	Insufficient HL	0.04	0.07	0.75	1.04	0.17	0.04	13.76***	1.18
PH	Limited HL	0.16	0.18	0.81	1.18	0.50	0.26	3.58†	1.65
	Insufficient HL	0.35	0.23	2.37	1.42	0.89	0.31	7.90**	2.44
ODC	Limited HL	0.05	0.04	1.10	1.05	0.02	0.04	0.32	1.02
	Insufficient HL	-0.09	0.06	1.80	0.91	-0.17	0.06	6.50*	0.84
ODSC	Limited HL	-0.05	0.05	1.18	0.94	0.03	0.02	1.27	1.03
	Insufficient HL	-0.01	0.07	0.16	0.99	0.03	0.04	0.66	1.03
Costs of doctor consultations									
GP	Limited HL	-0.03	0.26	0.16	0.96	0.01	0.01	0.68	1.01
	Insufficient HL	0.16	0.44	0.13	1.17	-0.01	0.02	0.13	0.99
SP	Limited HL	0.02	0.25	0.01	1.02	.03	.02	2.59	1.03
	Insufficient HL	-0.27	0.32	0.69	0.76	0.09	0.03	10.16**	1.10
GP	Limited HL	0.03	0.05	0.43	1.03	0.14	0.03	17.52***	1.15
	Insufficient HL	0.11	0.08	1.81	1.11	0.39	0.04	63.38***	1.47
Psychiatrist	Limited HL	0.12	0.06	3.59†	1.13	0.09	0.08	1.44	1.10
	Insufficient HL	0.31	0.09	12.46***	1.36	0.28	0.11	6.57*	1.33
Costs of medication use									
	Limited HL	-1.12	0.49	5.06*	0.32	0.08	0.02	11.28**	1.08
	Insufficient HL	-0.56	0.81	0.48	0.57	-0.18	0.03	22.84***	0.83

All the regressions included the covariates sex, age, education level, body mass index and health behaviours (diet habits, physical activity, smoking habits and alcohol consumption). Sufficient HL is the reference group.

GH = General hospital; PH = psychiatric hospital; ODC = One Day Clinic; ODSC = One Day Surgical Clinic; GP = General Practitioner; SP = Specialist Practitioner. IRR = incidence rate ratio defined as e β , where β is the regression coefficient.

Vandenbosch et al (2016) JECH

Health literacy as a possible mediator between low SES and health



Does health literacy mediate the relationship between socioeconomic status and health disparities? Integrative review

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Summary
While socioeconomic disparities are present, the most fundamental cause of health disparities, socioeconomic status (SES) does not impact health directly. One of the potential pathways between SES and health is health literacy (HL). We explored the role of HL in mediating the relationship between SES and health. We conducted an integrative review of the literature on the relationship between SES and HL, and between HL and health. We found that HL is a key factor in explaining the relationship between SES and health. HL is a modifiable and measurable factor that can be targeted in interventions to reduce health disparities. HL is a key factor in explaining the relationship between SES and health. HL is a modifiable and measurable factor that can be targeted in interventions to reduce health disparities.

INTRODUCTION
Socioeconomic status (SES) is linked to a wide range of health outcomes, including physical, mental, and social health. SES is a key factor in explaining the relationship between SES and health. HL is a modifiable and measurable factor that can be targeted in interventions to reduce health disparities.

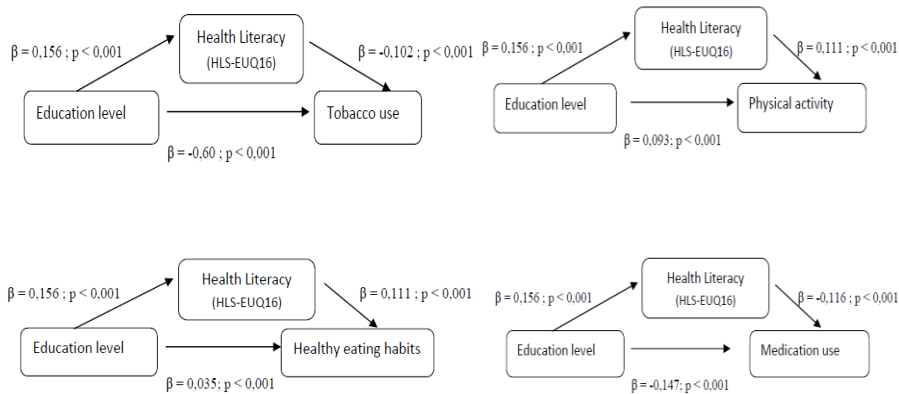
Low literacy may cause health disparities by

- reducing the accessibility to and the effectiveness of medical care received
- reducing the likelihood that individuals are adequately informed and activated with regard to healthy behaviors
- increasing a person's stress in addressing the challenges of navigating through daily life
- diminishing an individual's self-efficacy (i.e., the ability to exert control over one's life and surroundings)

Saha, *Journal of General Internal Medicine*, 2006, 21.8: 893-895.

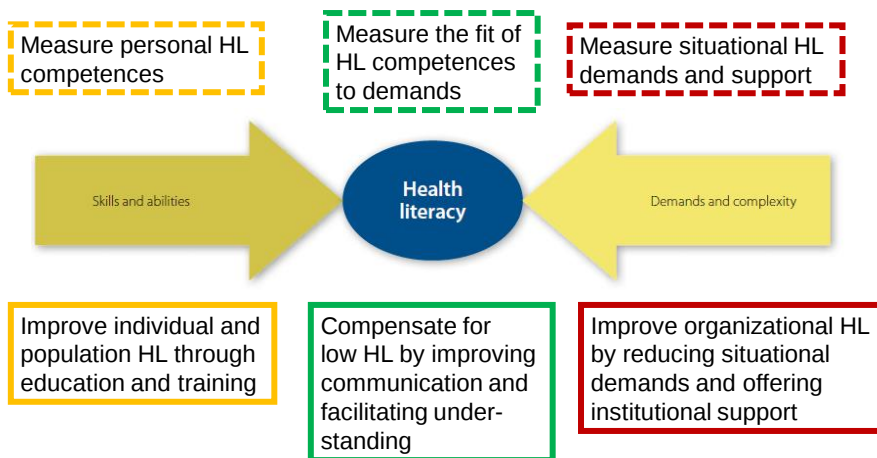
Health literacy as a mediator between education and health behaviour

Test of the mediating role of HL on the relationship between education and health related behaviour among 9616 Belgians



(Renwart & Van den Broucke, 2014)

Addressing low health literacy



Improve individual and population HL

Education and training

- Integration of health in educational programmes, professional training, and adult education



Policy measures

- Stimulate community development
- Specific actions for elderly and disadvantaged groups or communities



Creating and strengthening health literacy-friendly settings



1. Has leadership that makes health literacy integral to its mission, structure, and operations.
2. Integrates health literacy into planning, evaluation measures, patient safety, and quality improvement.
3. Prepares the workforce to be health literate and monitors progress.
4. Includes populations served in the design, implementation, and evaluation of health information and services.
5. Meets the needs of populations with a range of health literacy skills while avoiding stigmatization.
6. Uses health literacy strategies in interpersonal communications and confirms understanding at all points of contact.
7. Provides easy access to health information and services and navigation assistance.
8. Designs and distributes print, audiovisual, and social media content that is easy to understand and act on.
9. Addresses health literacy in high-risk situations, including care transitions and communications about medicines.
10. Communicates clearly what health plans cover and what individuals will have to pay for services.

Compensate for low HL by measures in the health sector

- Screening of low health literacy
- Adapt oral and written information in care and prevention by
 - balancing the depth of the information provided
 - checking comprehension
 - visual support of the communication
 - ensuring enough time for consultation
- Specific courses
 - e.g, self-management for chronic patients
- Communication training
- Use of social media



Examples: Specialised care



- An oncology service that uses **simple language** to give information to patients diagnosed with cancer, in order to improve the communication at further consultations
- A maternity **adjusting its communication to pregnant teens** in a language they understand and that appeals to them, to facilitate their participation in information sessions
- A hospital physiotherapist who develops a **clear exercise schedule** for the patient to perform at home when he is discharged from hospital

Examples: General care



- General practitioners who make use of a **computer program** allowing
 - better monitoring of chronic patients
 - better explanation of the illness and its treatment by showing pictures and drawings
- Home nurses who use a **spreadsheet** to help elderly and their caregivers
 - to monitor their medication use
 - to prepare for consultations with other health care providers
- The platform mondocasanté

<http://www.mijnthuisdoktermijngezondheid.be>



The role of Pharmacists

Pharmacists can implement verbal, written, and visual communication strategies to empower patients who must manage complex medication regimens

- **Verbal strategies**
Assess the knowledge gained by the patient through use of the teach-back method, in which the patient explains the information and instructions received back to the pharmacist
- **Written strategies**
 - Provide patients with written explanations, including medication action plans, to reinforce the main topics discussed
 - Avoid medical terminology, abstract concepts, categorical references, and value judgments.
- **Visual strategies**
incorporate visual explanations during the CMR diagrams and models can expand the patients understanding of the disease state

Example: personalised pill card

FIGURE 2

Sample pill card

Used for	Name	How to take it	Morning	Noon	Evening	Bedtime
Blood pressure 	Lisinopril 5 mg tablet	Take 1 pill every morning				
Diabetes 	Insulin glargine	Inject 20 units at bedtime				 Inject 20 units

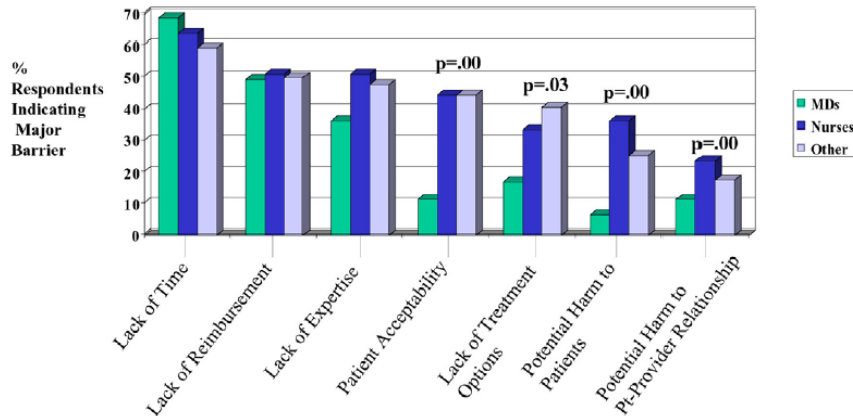
Created with tools available from the Agency for Healthcare Research and Quality.

Problems encountered by health professionals when acting on HL



- Health professionals and students are not necessarily selected for or trained in communication skills
- Health care driven by efficiency concerns
 - encounters with patients are limited in time
 - clear communication is not incentivized
- Lack of adequate health literacy awareness, knowledge and skills among health professionals
- Curricula and continued education programs are crowded

Health care professionals' attitudes towards Health Literacy Screening



Coleman, C. (2011). 4th Biennial Wisconsin Health Literacy Summit

Improving the HL competencies of health professionals



- Training of health professionals in recognizing and dealing with low health literacy
 - in professional education
 - in continuing education
- Development of Health Literacy Curricula
 - Principles laid down in the **Calgary Charter on Health Literacy**
 - Certification and accreditation systems for training programs
e.g., IUHPE Health Promotion Accreditation System
- Development of Health Literacy Toolkits
 - Instruments to measure / screen low health literacy
 - Tools to improve communication

Health Literacy toolkits



- Typically contain a suite of resources that can help to raise awareness of health literacy and upskill the health care and wider public health workforce
- Practical tools and techniques that practitioners can implement
- Provide examples of session plans to adapt and deliver similar workshop
- Showcase case studies
- Sometimes combine ICT-based elements with face-to-face elements

Health Literacy training for Health Professionals in the US

Web-based self-administered survey of all 133 US allopathic schools of medicine with membership in the Association of American Medical Colleges in 2010 (47% response)

In the required curriculum, what "health literacy" (or "health and literacy") items are being taught? (Check all that apply)	Percentage of Schools (n=44)
Prevalence of low literacy or low health literacy	70.5
Association between literacy or health literacy and patient outcomes	84.1
How to use a "teach back" or "show me" technique to check patients' understanding	70.5
How to use plain language skills (ie, the ability to communicate with patients in lay terms, without the use of medical jargon) for oral communication	95.5
How to use plain language skills (ie, the ability to communicate with patients in lay terms, without the use of medical jargon) for written communication	61.4
Other	11.4
In the required curriculum, how is "health literacy" (or "health and literacy") being taught? (Check all that apply)	Percentage of schools (n=44)
Lectures/didactics	84.1
Standardized/simulated patient encounters	56.8
Workshops/role playing	45.5
Assigned readings	31.8
Video	31.2
Experiences with adult low literacy (or low health literacy) patients	25.0
Online training	6.8

Coleman & Appy (2012). Fam Med, 44(7), 504-507.

Health Literacy training for Health Professionals in Europe



- Comprehensive health literacy communication training for various health professionals in Ireland, Italy and the Netherlands
- Addresses functional, interactive and critical health literacy through 5 training components
 - health literacy education
 - gathering and providing information,
 - shared decision-making,
 - enabling self-management
 - supporting behaviour change
- Potential for wider application in education and practice in Europe

Health Literacy training for Health Professionals : State of the Art



Systematic literature search on health literacy education interventions for health professions students, involving different health professions

Findings

- Significant **heterogeneity** in instructional methods and instruments
Instructional approaches range from single didactic to clinical and community placement interventions
- The most successful interventions are those that offer **numerous training sessions** and **integrate knowledge and skill acquisition** within **real-world settings** with patients or community members
- Future research should use an **agreed definition** of health literacy and provide a better understanding of the **impact** of health literacy training on specific health profession students

Towards Performance standards for HL training of Health Professionals

Journal of Health Communication, 33(2):102, 2013
Published with license by Taylor & Francis
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Health Literacy Practices and Educational Competencies for Health Professionals: A Consensus Study

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Health care professionals often lack adequate knowledge about health literacy and the skills needed to address low health literacy among patients and their caregivers. Many promising practices for mitigating the effects of low health literacy are not used consistently. Improving health literacy training for health care professionals has received increasing emphasis in recent years. The development and evaluation of curricula for health professionals has been limited by the lack of agreed-upon educational competencies in this area. This study aimed to identify a set of health literacy educational competencies and target behaviors, or practices, relevant to the training of all health care professionals. The authors conducted a thorough literature review to identify a comprehensive list of potential health literacy competencies and practices, which they categorized into 1 or more educational domains (i.e., knowledge, skills, attitudes) or a practice domain. The authors stated each item in operationalized language following Bloom's Taxonomy. The authors then used a modified Delphi method to identify consensus among a group of 23 health professions education experts representing 11 fields in the health professions. Participants rated their level of agreement as to whether a competency or practice was both appropriate and important for all health professions students. A predetermined threshold of 70% agreement was used to define consensus. After 4 rounds of ratings and modifications, consensus agreement was reached on 62 out of 64 potential educational competencies (24 knowledge items, 27 skill items, and 11 attitude items), and 12 out of 23 potential practices. This study is the first known attempt to develop consensus on a list of health literacy practices and to translate recommended health literacy practices into an agreed-upon

Developing a Competency-Based Pan-European Accreditation Framework for Health Promotion

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Abstract

Background: The CompHP Pan-European Accreditation Framework for Health Promotion was developed as part of the CompHP Project that aimed to develop competency-based standards and an accreditation system for health promotion practice, education, and training in Europe. **Method:** A phased, multiple-method approach was employed to facilitate consensus building with key stakeholders in health promotion across Europe. Consultation processes included focus and discussion groups at European and country levels, an online survey, a web-based consultation, and testing in academic and practice settings. Successive drafts of the Framework (a total of five) were revised based on the feedback from each consultation stage. **Findings:** A total of 403 participants from 29 of the 34 target countries contributed to the consultation process. The overall response to the Framework was positive, with negative feedback focusing mainly on the barriers that may impact on its implementation. **Conclusions:** The CompHP Pan-European Accreditation Framework for Health Promotion provides an agreed system to promote quality assurance and competence for health promotion practice and education in Europe. The Framework, which builds on the CompHP Core Competencies and Professionals Standards, outlines the systems and processes for the accreditation of health promotion practitioners and health promotion education and training by accrediting organizations at national and European levels.

Keywords

accreditation, health promotion, quality assurance, workforce development

Future trends



- Health literacy as a quality indicator for health services
- Training of health professionals to detect low health literacy and take compensatory measures
- Development of Health Literate Systems
- Relationship of health literacy with other « literacies » (digital literacy, media literacy, ...)
 - E-health : increasing reliance on ITC for health information offers both opportunities and challenges
 - Addressing DHL involves building digital skills and knowledge + designing health IT tools that are navigable for less health literate patients
- Collaboration to address health literacy

