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Health literacy: What lessons can be learned from the experiences and policies of different countries?

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Abstract

Background: Adequate levels of health literacy (HL) are crucial to ensure good quality of health, social life and well-being. HL is a mediating factor in health disparities. Low HL hampers interaction with healthcare. HL is a shared responsibility of individuals and the healthcare system. Multi-dimensional programs and policies should be set up.

Aim: To learn from current HL policies and action plans and to identify elements to consider for the development of national HL plans.

Method: Transversal analysis of HL policies in six countries, based on a preliminary scoping review. A combination of document analysis and key informant approach. Local experts validated and completed information for their country. A transversal comparison was performed.

Results: Several approaches were identified, often influenced by contextual factors, healthcare reforms and existence of centers of expertise. Some governments developed full-fledged, standalone plans, while others developed broader plans covering the entire health and care sector. Some took a conceptually driven, high level approach. Others took a pragmatic approach. And some did not have a governmental plan at all.

Conclusion: Policy makers should analyse their state structure and health system, and search for local 'pockets of excel-

lence', to develop a well-planned, substantiated HL approach for their country.

KEYWORDS
health care disparities, health literacy, quality of health care

Highlights

- Adequate levels of health literacy are crucial to ensure good quality of health, social life and wellbeing
- Health Literacy is a shared responsibility of individuals and the healthcare system.
- National health literacy approaches are often influenced by contextual factors, healthcare reforms and existence of centers of expertise.
- Governments can decide to develop full-fledged, standalone plans, or to develop broader plans covering the entire health and care sector.
- Governments can decide to take a conceptually driven, high level approach, take a pragmatic approach, or choose not to installl a policy plan.
- Policy makers should analyse their state structure and health system, and search for local 'pockets of excellence', to develop a well-planned, substantiated HL approach for their country.

1 | INTRODUCTION

Health Literacy (HL) can be defined as '*people's knowledge, motivation and competencies 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*'.[1] While it is generally acknowledged that reading and writing skills are important to access and interact with the healthcare system, this definition shows that HL must be conceived as a broader concept that also includes cognitive, critical and communicative competencies.[2] Since the nineties, there is a growing awareness that higher levels of literacy are related to more opportunities in life, higher levels of employment, and more social engagement.[3] A broad range of studies have demonstrated the relationship between HL and health outcomes in terms of knowledge, behaviour, morbidity and mortality,[4] and suggesting that literacy may also be an important mediating factor in health disparities.[5] These studies also revealed that in many countries there is limited HL among large shares of the population.[6,7]

People with low HL face serious problems when interacting with the healthcare system, such as limited participation in health promotion and disease prevention measures, inadequate management of chronic diseases, increased hospitalization rates, and higher odds for re-hospitalization.[6] They have problems in establishing contacts with healthcare professionals, accessing healthcare institutions, making shared decisions, understanding the pathophysiology of a health condition, following treatment instructions, and taking up responsibility for their own health. Consequently, HL is generally recognized as a critical determinant of health. This is attested by international key political statements at European and global level. The WHO 2016 Shanghai Declaration[8] commits to '*develop, implement and monitor inter-sectoral national and local strategies for strengthening health literacy in all populations and in all educational settings;*

increase citizens' control of their own health and its determinants, through harnessing the potential of digital technology; ensure that consumer environments support healthy choices through pricing policies, transparent information and clear labelling.'

While early definitions of HL were mainly focused on the patients' skills to access and understand the healthcare system, recent studies put more emphasis on the match between the demands of the care system in terms of health information and a person's (health) literacy.[6] This is equivalent to switching from an 'individual deficit' perspective to a more 'system-wide asset' model.[9] Indeed, a person's level of HL is not only influenced by individual characteristics, but also by the cultural and social environment and by the way healthcare is organized and information about health is provided and communicated.[10] A complex healthcare system makes it more difficult for users to act as health literate persons.[11] This paradigm shift makes HL a shared responsibility of individuals and healthcare organizations,[12] and opens up the possibility to develop and implement multi-dimensional intervention programs and policies that take all the aspects of HL into account.

The broader the definition of HL, the more difficult it is to measure it. Nevertheless, tools have been developed that capture more comprehensive conceptualizations of HL. One of the best-known measures of 'complex' HL is the questionnaire that was developed for the European Health Literacy Survey (HLS-EU),[13] used in eight European countries: Austria, Bulgaria, Germany, Greece, Ireland, the Netherlands, Poland and Spain. The instrument was based on a broad conceptual model of HL and validated for the eight participating countries. The results indicated that, although the figures differed substantially across countries, at least 1 out of 10 of the respondents showed insufficient HL, and almost 1 out of 2 had limited (insufficient or problematic) HL. The survey also identified subgroups that were more vulnerable for low HL, such as persons with a low social status, low education, or old age.[7]

As the definition of HL broadened over time, the ways to address low HL also have expanded from actions and interventions targeting individuals to ones aimed at the entire healthcare system. Murugesu et al.[14] propose three levels of action:

(1) At the *micro level*, HL is addressed in the direct interaction between the health (and social) care professional and patient. Apart from providing simple, understandable and reliable information, patients must be supported so they feel motivated and able to use that knowledge.
(2) At the *meso-level*, HL can target the way care provision is organized at the level of the institution or private practice (e.g., user-friendliness of the appointment system, signalization in hospitals, comprehensibility of information material, availability of eHealth and ICT tools, etc.). To achieve this, training of healthcare workers is of paramount importance.
(3) At the *macro-level*, addressing HL involves creating the general framework conditions for taking account of HL in all sectors of society. HL should be a concern for health policies at all political levels, both within the health sector (e.g., commitment of the health insurers, participation of professional associations, etc.) and in other sectors (e.g., education, the workplace, the media, food production, …).

Of these three levels, the first one has proliferated the most, in the sense that a large number of initiatives exist to address HL in the interaction between patient and health or social care professional. These initiatives are mostly based on good intentions, but often suffer from a lack of financial or organisational support. Initiatives at the meso-level are beginning to emerge as well. In contrast, macro-level framework development through policies that give HL a place in different sectors are still rare. Nevertheless, some countries have taken the initiative to develop HL policies and action plans to coordinate efforts to address HL at different levels and, sometimes, across sectors. The goal of the present study is to learn from these HL policies and action plans and identify elements and criteria to consider for the development of national HL plans.

2 | METHODOLOGY

A transversal analysis was performed of HL policies in six countries that have developed a HL policy. The selection of these countries was based on a preliminary scoping review regarding the availability of publications and information regarding regional or federal HL policies. The main selection criteria were the organization of healthcare, the inclusion of countries with a unitary and federal state structure, and the availability of best practices. This resulted in a selection of 6 countries:

- Australia is very active in research on HL;
- Austria heavily invested in HL after the HLS-EU study and reached very good results in a short time;
- Ireland has a HL policy that is, mainly driven by the non-governmental sector;
- The Netherlands has very high levels of HL;
- Portugal recently invested much energy in enhancing HL in the population after a survey showed that the Portuguese scored low on HL compared to other European countries;
- Scotland is a nation within a federation of states that has a very interesting HL action plan that appears to be very successful.

To analyse the HL policies of the selected countries, a combination of document analysis and key informant approach was used. In a *first step*, a document search was performed (in October 2019) for publications in scientific and grey literature databases (Pubmed, Cinahl, Embase, OAISTER, OpenDOAR), using internet search engines and governmental websites, with variants, translations and combinations of the search terms 'health literacy', 'health care policy', 'best practice', 'patient empowerment' and 'health care organization'. All documents describing policy activities or decisions at a national or regional level were taken into account. Based on content and references lists, additional relevant documents could be identified. To structure the information from these documents, an analytical grid was used, based on the frameworks used by Rowlands et al. (2018)[15] and Cheung et al. (2010).[16] This allowed to retrieve and structure information with regard to the background of the country's political system, the initiation of a HL policy, the methods used to develop a HL policy plan, financial resources, stated goals, main actors, beneficiaries, actions, timing, opportunities, threats, evaluation, monitoring and impact. Issues such as monitoring and assessment would ideally have been taken into account as well, but information on those aspects was missing in almost all the considered plans. In a *second step*, local experts with expertise in HL policies were identified for each country to validate and complete the information provided for their country. For that purpose, they were interviewed by video-conference. In a *final step*, a transversal comparison was performed on the grids obtained for all six countries.

3 | RESULTS

As revealed by the document analysis, three of the six selected countries (Australia, Portugal and Scotland) developed full-fledged, standalone action plans on HL, supported as such by the authorities. Two other countries (Austria and the Netherlands) developed broader action plans that cover the entire health and care sector but also include elements that relate to HL. Ireland has both, but only the national plan is supported by the authorities.

3.1 | Background of the HL plans

Most of the policy plans included in this study were initiated after the publication of the results of the European Health Literacy Survey (HLS-EU) or of results from national population-level HL measurements inspired by the European survey. The Australian plan was initiated after the first Adult Literacy and Life Skills Survey (2006).[17]

For some countries, the development of the HL action plan took place within (or parallel to) a reform of the country's healthcare system. This is the case for Australia, Austria, Portugal and Scotland. The Australian health reform program aimed to improve the effectiveness, efficiency, appropriateness and accessibility of healthcare, focussing on eight streams: hospitals, general practice and primary health care, elderly care, mental health, national standards and performance, workforce, prevention and e-health.[18] The HL action plan is part of the national standards and performance stream, as a criterion within one of the standards, concerned with 'Partnering with Consumers'.[19] In Austria, the ongoing healthcare reform is mainly focused on structural aspects of healthcare, but since the majority of HL interventions take place within healthcare, this reform was a good opportunity to improve HL. One of the ten inter-sectoral health targets set by the Austrian government is to improve HL in the population, which is considered a top priority. Portugal also builds its HL policy plan within a health services reform (*SNS + Proximidade*), which aims to place the citizen central in the health system. In Scotland, a strategic momentum to conceive a HL action plan was created with the *2020 Vision for Health and Social Care* (2011),[20] which aimed to achieve sustainable quality in the healthcare services across Scotland, with a focus on prevention, anticipation, supported self-management, and person-centered care, inspired by the *Healthcare Quality Strategy for NHS Scotland* (2010)[21] and the *Patient Rights Act 2011*.[22] The current Scottish HL plan (2017–2025) is an adaptation of the first one. Meanwhile, three annual reports (2016, 2017 and 2018) on 'Realistic Medicine' are published, which insist on better supporting the people's needs through shared decision-making and a focus on improvement of HL.[23–25] Scotland also mentions the influence of global movements like *Choosing Wisely*, which have brought a focus on supporting people to make better decisions about care.[26]

3.2 | Development of the HL plans

3.2.1 | Political context

The development of programs and activities to address HL can occur without the existence of a national action plan or policy. It is more dependent on factors such as the awareness of HL, the presence of a strong non-governmental sector, the organization of the healthcare system, the conception of civil rights, and the availability of financial incentives.[27] Nevertheless, the political organization of a country, including its federal structure, and the context of its health system are key factors in the nature and scope of action plans and policies like the ones for HL.

In Australia, the federal government and the State and Territory governments have a shared responsibility for the health policy and for the management of the healthcare system. This multi-tiered system makes coordinated action difficult, as health workers often work in silos.[28] For that reason, the HL "plan" was developed at the federal (national) level. The Australian HL plan is a *National Statement*, and its endorsement by all Federal, States and Territory health ministers signals a commitment of principle to addressing HL across Australia.[12] The policy context is similar in Austria, where the Ministry of Health, the Austrian *Länder* (States) and the health insurance funds have a shared responsibility for the health sector. As the influence of the federal state is rather limited compared to that of the 'Länder', significant differences in service provision can occur between the Länder.[29] Thus, the 10 targets of the federal Austrian HL Plan[30] are based on common principles ('orientation towards health determinants', 'Health-in-All-Policies (HiAP) approach' and 'promoting health equity'), and should be considered as 'declarations of intent' with scarce implementation power.[31] Scotland, on the other hand, is a nation within a federation of countries (UK) and is autonomous for the management of its health care sector. Since there is no UK-wide policy on HL, the HL-action plan could be developed autonomously by the Scottish Government in collaboration with the National Health Service (NHS Scotland).

As opposed to Australia, Austria and the UK, Portugal, Ireland and the Netherlands are countries without a federal structure for HL. In Portugal, the Ministry of Health is responsible for the health policy at the national, regional and local level, which facilitates the implementation of policies to promote HL at all levels. The Portuguese HL Plan is part of a National Health Plan, the principles, objectives and goals of which guided its development.[32] In Ireland, the government's commitment to addressing HL is part of a reform of the health policy named 'Healthy Ireland: A framework

for improved health and wellbeing 2013–2025'.[33] In the Netherlands, actions addressing HL occur more independently from the health system, and don't have a strong medical perspective as is the case in most other countries. Instead, they are driven by societal networks which consider HL more from a patients' rights perspective.

3.2.2 | Initiation

In four of the six countries (Austria, Australia, Scotland, Portugal) the HL policies and action plans were initiated by the public authorities. In The Netherlands and Ireland they were initiated by the non-governmental sector (i.e., non-governmental organizations). As opposed to an action plan initiated by the authorities, which is implemented top-down, a plan initiated by the health and social sector must be taken up by the government for further coordination and funding. But even when an action plan is initiated by the public authorities, different dynamics exist. In Portugal and Scotland the plans were developed by the Ministry of Health, whereas in Australia the initiative came from a specific body within the health authorities, the Australian Commission on Safety and Quality in Health Care (ACSQHC).[34] In Austria, the HL plan was an initiative of the entire government, as an emanation of the Health in All Policies (HiAP) approach.[35] The two examples of initiatives arising from NGOs show a bottom-up process. In Ireland, the development of a HL policy was driven by the National Adult Literacy Agency (NALA), an independent (lobbying) charity.[36] In the Netherlands, the promotion of HL was initiated by the Alliantie Gezondheidsvaardigheden,[37] a non-governmental voluntary collaboration of more than 80 partners. This alliance collaborates with a governmental initiative, Alliantie Gezondheid en Geletterdheid.[38] The coordination of the collaborative actions is done by a not-for-profit organization.

3.2.3 | Stakeholder and expert consultation

In government-driven HL policies, public authorities generally set up a working group with various stakeholders to assist in the development and implementation of the action plan. When the plan originates from NGOs, these responsibilities are taken up by field organizations themselves, which then eventually receive support of the authorities. Working groups can be *permanent*, as in Austria, where elaboration of the Health Targets relied on a consultation process of all relevant political, social and societal stakeholders[30] as well as on an online participation by citizens. In Scotland, the working group is *temporary* and ad hoc. For the first HL Plan, a *National Health Literacy Action Group* (NHLAG) was set up, involving experts in public health, policy, academia, clinical practice, law, health equity and health and knowledge information.[39] This NHLAG successively developed the definition of the problem, an overarching goal, the specific scope, and prioritization of specific actions in a collaborative way. For the second HL plan a new working group was set up, replacing the first one. Portugal combined both types of working groups. First, a leapfrogging approach was followed, for which several successive working groups were convened composed of Portuguese experts, WHO experts, and various stakeholders (not necessarily in relation with HL) from local government, education, health professions, academia, the media and civil society. They had to gather information and build a first draft of the plan. Then a more permanent monitoring commission was established of 15 experts from different backgrounds (public health, marketing, psychology, information systems, consumer representatives…) to support the prioritization of actions and measures, and as a resource for the development of strategic information and follow-up.[40] In Australia, the process was conducted by an existing official body (ACSQHC) which organized the consultation process. This involved stock-taking of policies, programs and other activities regarding HL through a consultation of State and Territory health departments, other government agencies, health services, advocacy organizations, and consumer organizations. An evidence-based draft document describing the conceptual framework for the plan was submitted for national consultation, and all stakeholders and the public were invited to comment and provide input, which resulted in the final version of the background paper and statement.

3.3 | Implementation

3.3.1 | Main actors

Actors who are involved in the implementation of HL action plans can be divided into the micro, meso or macro level. At the macro-level, governments are indispensable primum movens actors. In Austria, the government promotes a *Health in All Policies* approach and mobilizes sectors other than health care to set up multi-sectoral actions involving education, media, social networks, academic researchers, and the private sector to address HL. The meso-level encompasses the whole health sector (healthcare institutions, private practices, health insurance funds, professional organizations and patient organizations). Again in Austria, public health and health promotion experts are called upon to develop and evaluate HL programs and interventions. Scotlands' national plans put the focus on the social aspect as an essential component of healthcare. The Australian National Statement emphasizes the role of the 'nonclinical workforce', such as receptionists, volunteers, kitchen staff and cleaners, who often interact with consumers and have an important role in creating a HL friendly environment. Lastly, the micro-level focuses on the interaction between the patient/client and the health system. This means that both the healthcare providers and the individual patient/client must be considered: the first can contribute to a better quality of patient interaction and must be trained to use supporting techniques and tools, while patients/clients, relatives, and patient organizations can be made aware of their rights and responsibilities. In this regard, the Austrian action plan mentions specific actors from civil society, like teachers, persons involved in extra-curricular youth work, women's health centers, enterprises, municipalities, etc. In Scotland, public libraries are also involved.

3.3.2 | Partnerships

Many policies and action plans for HL do not make a clear distinction between actors and partners. The Portuguese HL action plan broadly mentions several partners, such as public, social and private sectors, Ministries and Inter-ministerial Commissions, universities, professional orders, scientific societies, NGOs, media, civil society, and patient associations (p. 12). The Austrian intersectoral platform brings together representatives from the federal government, the 9 Länder, the health insurance institutions, the HiAP partners (i.e., Ministries of Education, Labor, and Social Affairs) and approximately 50 member organizations (i.e., partners of healthcare, education and welfare systems, as well as societies and NGOs). In Australia, ACSQHC collaborates with patients, caregivers, clinicians, the Australian State and Territory health systems, the private sector, managers and healthcare organizations. In the Netherlands, partnership is the very essence of the HL policy, with more than 80 organizations working voluntarily under the umbrella of the Alliantie Gezondheidsvaardigheden,[37] including academic and research institutions, health care provider organizations, patient organizations, industry and business, health insurers and local institutions and initiatives.[27] In Ireland, the HL action plan is supported by a multi-stakeholder collaboration grouping NALA, the Departments of Health, Children and Youth Affairs, and Education and Skills, the Health Service Executive, statutory agencies, community and voluntary bodies, university departments and the private sector. The Scottish HL action plans rely on partnerships with, amongst others, the Health and Social Care Alliance Scotland. This Alliance is the national third sector intermediary for a range of health and social care organizations, with over 2700 members including large, national support providers as well as small, local volunteer-led groups, disabled persons, people living with long term conditions, and informal caregivers,[41] but also NHS Boards, Health and Social Care Partnerships, Primary/Community Care practices health and social care professionals, and even commercial organizations. Other partners are the Scottish Public Health Network,[42] the Scottish Council for Voluntary Organizations[43] and the Patient Partnership in Practice (P^3) network.[44] In summary, all HL policy plans studied bring together organizations from the non-profit sector and official/political instances. In some cases, as for instance in Scotland, the policy is intentionally deployed top-down to meet and involve

the community associations and receive their support, whereas in other countries, such as Ireland and the Netherlands, the initiative comes from the sector and receives a political support.

3.3.3 | Existing actions versus new ones

A HL plan does not replace actions that are already taken. The two countries where the HL plan started from the non-governmental sector quite naturally rely mainly on organizations that were already working on HL to continue their existing activities. However, while in Ireland NALA is the only actor promoting HL country-wide, the Alliantie Gezondheidsvaardigheden in the Netherlands has to facilitate existing initiatives regarding HL under a common umbrella. In a similar vein, the Australian National Statement acknowledges the existence of '*many pockets of excellence and innovation contributing to a patchwork of health literacy activity*' (p. 30). The Portuguese HL plan combines both approaches and promotes existing actions as well as develops new ones. In Austria, initially all interventions submitted to the OEPGK had to be new to avoid window-dressing, but as this condition would rule out valuable existing interventions, some of these were included.[31]

3.3.4 | Financial resources

There is a clear difference in funding between government-led HL policy plans and programs driven by NGOs. For the first, public funding of activities to put the HL plan into action is provided by the authorities, whereas initiatives from the NGOs often rely on private resources. This was the case in Austria, where the financial resources allocated to HL within the Health Targets are limited, so organizations have to find resources on their own.[31] As a result, interventions depend on offers made by experts and stakeholders who have the power and means to bring action into practice.[29] With the Healthcare reform, the Ministry of Health, the 9 Länder and the umbrella of health insurance funds agreed to allocate financial means to pre-defined topics. This budget is managed by the Austrian inter-sectoral platform OEPGK, funded through the Austrian Health Promotion Fund (FGÖ).[45] This guarantees independence for the platform, but also limits its scope of activities since the Fund's focus on health promotion does not permit to fund interventions in healthcare.[29] Apart from an early measurement of HL in Austria, no private money went into HL interventions in Austria thus far.

In Australia, no public funding is provided nationally to implement the National Statement. Although the National Standards include HL related requirements for health services (e.g., to improve wayfinding and navigation in hospitals), no funding is attached, yet state health departments and local health districts may decide to provide funds locally. For the ACSQHC, costs are shared by Federal and State and Territory health agencies. In Scotland, the government funds actions proposed in the 'Making it Easier' plan through collaboration with departments across the health and social care landscape (NHS Scotland, the voluntary sector and third parties).[46] In Portugal, the implementation of the action plan is funded by the Directorate-General of Health, without external funding. In Ireland, NALA collaborates with the pharmaceutical company MSD, which sponsored a survey amongst GPs and an audit of HL in healthcare settings,[47] and is the main sponsor of the Crystal-Clear MSD Health Literacy Awards, which aims to identify best practices and reward innovation in the field. Currently, NALA and MSD run the Crystal-Clear accreditation program for GPs and pharmacists.

3.3.5 | Timing

Contrary to the detailed statement of goals, the time frame for accomplishing these are generally not well detailed in the action plans. Only the Portuguese plan presents a detailed roadmap with concrete implementation milestones,

scheduled between January 2019 and December 2021.[48] In Austria, the 10 Inter-sectoral Health targets must be reached in 2032, but the healthcare reform has a much tighter timing, with a first period from 2013 to 2017 and a second period lasting until 2021. In Scotland, the first national HL plan was scheduled from 2014 to 2017. For the implementation of the second plan a larger time frame is foreseen (2017 to 2025). Since the Netherlands have no standalone national policy on HL, there is also no timing, but the Alliantie Gezondheidsvaardigheden has a multi-annual work plan, the current one covering 2017–2019.[37] In Australia the national statement also does not set any time limits, but the process of implementation of the standards and health services is assessed every 3 years.

3.4 | Content of the HL policy plans

3.4.1 | Beneficiaries of the actions plans and policies

While the HL policies and action plans of all six countries cover the entire population, some pay extra attention to specific groups. For instance, the Portuguese HL policy plan follows a life cycle approach and focuses especially on critical moments of life transition, such as university entrance, labour market entry, retirement, etc. Moreover, all countries pay specific attention to vulnerable groups. Ireland defines these as 'people with disabilities, health and mental health problems, the unemployed, disadvantaged communities and minority groups'. In Austria the vulnerable populations are defined as persons over 65, low-income people, migrants, educationally disadvantaged groups, and persons with chronic illness, while particular sub-policies are targeted to specific groups (e.g., people with impaired hearing). In the Netherlands, HL interventions target vulnerable/minority groups and HL in occupational environments in accordance with partner organizations' activities. The current (fifth) prevention program (PP5) focuses on development of knowledge for schools, neighbourhoods, work environments, care and health prevention.[49]

3.4.2 | Announced goals and strategies

Based on the classification of Murugesu et al.[14] actions can be split into micro-, meso- and macro-level. The goals of the studied action plans and policies range from a very concrete micro/meso-level (Scotland) to a very global *'Health in All Policies'* macro-level (Austria).

The most frequently mentioned goal in the action plans and policies is *awareness raising*. This can be considered as the common denominator of all national policies to improve HL. Awareness raising can be oriented at a global (macro) level or directed towards health professionals (meso-level). In Australia, the goals of the National Statement are oriented towards increasing awareness and fostering a climate that promotes national action and collaboration on HL (macro-level), with specific focus on the integration of HL in education. In Austria, the inter-sectoral Health Target focussing on HL sets three priorities: (1) improve individual HL with focus on vulnerable groups (micro-level); (2) improve organizational HL-friendliness (meso-level); and (3) improve HL-friendliness of the whole economic system (macro-level). For the healthcare reform a mix of micro- and meso-level goals have also been advanced, including (1) improve the quality of communication by training healthcare professionals; (2) improve the quality of written and audio-visual information by providing writers, financers and publishers a set of criteria and skills; (3) improve the organizational health-literacy responsiveness by providing self-assessment tools and guidelines; and (4) empower citizens and patients.[50] The last goal is also formulated at macro-level, and involves the monitoring of the level of HL in the population through the European Network on Measuring Population and Organizational Health Literacy (M-POHL). In Portugal, the national HL plan aims at *increasing HL levels among the population in a sustainable way, thus enhancing their ability to navigate the Portuguese National Health Service within the context of their everyday lives and improving self-care and disease management*.[51]

In terms of goal formulation, the HL policy plan of Scotland is more focussing on the meso level, aiming to establish a healthcare culture and practice which supports equal access, collaborative working and self-management. To achieve this, Scotland has chosen a progressive approach. The stated goals of the first national plan, *Make it Easy*, were formulated at the micro level: they included awareness raising for HL within the workforce, improving access to HL techniques and resources for health professionals to improve their capacities to address low HL, and developing new tools and innovations in enabling approaches, with a specific attention to transitions of care (i.e., hospital discharge, informed consent, or changes in medication). The second plan, called *Making it Easier*, builds on the first one but is more oriented towards organizational HL (meso-level), aiming to develop supports and services to better meet people's HL levels.

Contrary to the abovementioned countries Ireland and the Netherlands have not formulated specific HL related goals. The government-led *Healthy Ireland* plan is not specifically devoted to HL, although one of the goals is de facto targeting HL by 'empowering people and communities' with the aim to foster the implementation of mutually reinforcing and integrated strategies and actions to encourage, support and enable people to make better choices for themselves and their families. Of the 12 actions, proposed under this theme, only one specifically mentions HL, but others promote HL in a broader sense and cross-sectorally. More concrete strategies to improve HL are also found in practice, where the NALA charity acts as a strong lobbying force for HL through research, awareness raising, training and accreditation of healthcare professionals, integrating HL considerations into all national health campaigns, and screening projects. Like Ireland, the Netherlands have no HL plan as such, but the aim of the Alliantie Gezondheidsvaardigheden is to reduce health inequalities and focus on people with limited HL. This is embedded in an inter-sectoral national program for prevention 'Alles is Gezondheid' (2014–2017, 2017–2021).[38]

It is interesting to note that quantified targets are generally missing, the only exception being the Austrian target to improve the proportion of Austrians with sufficient and excellent HL as measured by the overall index of the HLS-EU survey to 55%.

3.4.3 | Actions

In all of the countries the action plans include a broad range of interventions at macro, meso and micro level. Examples of macro-level interventions are:

- embed HL into government legislation, policies and plans;
- embed HL into standards and funding mechanisms;
- systematically include HL and health promotion as part of the professional competencies of all healthcare providers and social workers;
- systematically include communication, conversation and empowerment skills as part of the professional competencies of all (future) healthcare providers and social workers;
- develop standards for evidence-based communication training for of all healthcare providers and social workers, according to the Calgary Charter[52];
- consider communication, conversation and empowerment skills as criteria for the accreditation of healthcare professionals;
- consider to integrate (self-)audits for HL friendliness into the standards for health care;
- fund and launch awareness raising campaigns, population health programmes, health promotion, education and social marketing campaigns, etc.;
- generalise the use of patients' electronic health-records and accompany this with the necessary support in order to become real tools for empowerment.

- Fund and participate in national and international research initiatives (e.g., M-POHL survey) or in other international initiatives like the WHO European Region Action Network on Health Literacy for Implementation of Prevention and Control of NCDs (Portugal).

While many action plans refer to trans-sectoral policies in the formulation of their goals, not many concrete examples of actions to pursue these goals were found, except for the mentioning of education of children in the Australian National Statement.[53]

Details and full references of the action plans at macro, meso and micro level per country are provided in a separate report.[54] Although interventions at meso and micro level are out of scope for this paper, it is clear that the three levels are strongly linked and interact with each other. For example, 'embed HL into standards and funding mechanisms' (macro) could favour the selection of HL-friendly projects among others at the level of health institutions (meso) or of the civil society (micro). And 'systematically including HL and health promotion as part of the professional competencies of all healthcare providers and social workers' (macro) will result in better sensitization of the health professionals and increased use of supporting HL-tools by professionals and patients (micro).

3.5 | Opportunities and threats

The fact that some of the HL action plans are implemented as part of a reform of the country's healthcare system greatly enhances the chances of success. For instance, the Portuguese HL Action Plan was developed in parallel with the National Health Plan, and sees the HL action plan as an opportunity to reassess the needs and update the Health Plan, so that it will be more focused on identified needs. Another opportunity is that many stakeholders and decision makers in public health and healthcare are convinced of the importance of HL. This is the reason why the Austrian government devoted one of the ten inter-sectoral health targets to the improvement of the HL level in the population. Consumer health organizations at the national, state and territory level who recognize the importance of HL may advocate to funders, regulators and providers of health services. An example of this is given by Trezona et al., who criticized the current HL policies in Australia as '*largely failing to address health literacy across key life stages and in key health-promoting settings such as in schools, workplaces and other social/community environments, despite the wide acknowledgement that health literacy is content and context-specific*', and further argued that '*…current policies give very little attention to the health literacy needs of specific population groups, or the need to consider factors such as culture, language, gender, sexuality and disability*.' (p. 479).[12]

A disadvantage of government-driven policies is, however, that they are vulnerable to political changes, which threatens their sustainability. This was explicitly noted for Austria and Portugal, where elections were planned at the time of this study. In Portugal, it was feared that a change of government would lead to a lower capacity to broaden the communication towards the entire population. In Austria uncertainty arose about the continuation of the financing for coordination and interventions around HL. Such challenges are less present when the initiative originates from the non-governmental sector. Therefore, advocates of HL emphasize the importance of establishing an inter-sectoral platform that can demonstrate the effectiveness of HL related activities and prove their economic benefits for healthcare system.[29] It is also hoped that the new European HL Survey (HLS-EU19), which takes place under the auspices of WHO-Euro, will provide robust empirical data regarding the link between HL and the usage of healthcare services.[31]

Another challenge seen in Austria is a form of ideological reluctance, in the sense that many actors are not yet convinced of the need for health organizations to improve their responsiveness, in addition to raising the HL level of patients and citizens.[31] Formal regulations will be required to encourage institutions to implement the principles of health-literate organizations in their daily functioning.[29] On the other hand, some parties fear that the focus on HL might lead to "blaming the individual", whereby individual patients and citizens are held accountable for adverse health outcomes. Instead, the focus must be on further developing the health system (the society as well as the healthcare institutions) to meet population and patient needs (political accountability).[29]

A last challenge to addressing HL is the strong drive for enhanced effectiveness that is put on health systems, leading to time-pressure and reduced capacity. This threat can to some degree be mitigated by incorporating HL in the mandatory standards, as is the case in Australia, but this only holds true for part of the system, and not for primary care.

3.6 | Evaluation of the HL policies and plans

In contrast with the growing attention of researchers for the evaluation of concrete HL interventions, there is very little information about evaluation of HL policy and action plans. Only a few countries (plan to) evaluate the implementation of their HL policy plans, and most of them limit the evaluation to that of individual interventions. The interviews with national experts revealed that the reasons for this are mainly practical. In Austria, the monitoring of the implementation of the inter-sectoral Health Targets is done in combination with that of other strategies, such as the health reform process, the health promotion strategy and the health strategy for children and young people, which makes the overall picture a bit of a mosaic.[31] In Scotland, evaluation was considered from the very conception of the national HL plans, but it was decided to keep it very pragmatic. Indeed, *'since the main goal of the [first] Plan was to initiate health literacy action, the evaluative priority was to explore what possibilities would emerge and how, rather than focus on specific health, personal or economic outcomes'* (p. 424).[55] For the second Plan, which is currently being implemented, the emphasis will be on improving the quality of people's experience with the health and care system. Simple measures such as confidence scales will be used to show improvements in awareness, understanding and confidence, all of which are considered as markers of improved health literacy responsiveness.[55] In other countries evaluation of implementation is still in the planning stage. In Portugal, a set of indicators will be defined that will allow to assess compliance with and success of the plan, and show the need for adaptations. In Australia, the National Standards will probably be used to measure action on HL within parts of the health system. However, as the implementation of these standards have only just began, it is too early to expect results.

4 | DISCUSSION

The international comparison presented in this study revealed a diversity of scope, focus, detail and level of implementation for different national policy and action plans for HL. These differences are understandable given the diverse governmental structures of the countries, the organization of health systems, and the way HL was brought to the policy agenda. Despite these differences, three broad approaches can be identified.

The first one is a *conceptually driven* approach, as in the Austrian HL Policy Plan and the Australian National statement. This approach is based on theory-informed international standards, such as the multidimensional definition of HL and the holistic HiAP concept. The plans or statements are typically formulated at the federal level, while their implementation is a task for the decentralized level. The goals and targets for this approach are ambitious and aspirational, but as their implementation requires joint efforts from a large number of actors, many of which are outside the health sector, they rather serve as declarations of intent, without much implementation power. In the case of Australia, the National Statement does not even represent a formal government policy, but rather a commitment to addressing HL by creating the conditions to develop and implement action plans at State level. However, despite the low leverage for action, these plans can be a symbol of the country's determination to improve HL throughout its political system and at all levels of governance.

The second approach is a *pragmatic* one, as in Scotland and, to a lesser extent, Portugal. This approach uses the opportunity of a health sector reform to introduce a focus on HL. By focussing on the healthcare workforce, energy can be mobilized to develop goals and actions to improve the critical interface between patients and the health care system, where people are directly confronted with their own health issues. In Scotland, the first action plan was almost

exclusively targeted towards the healthcare sector and involving micro-level interventions, but then gradually broadened its scope towards taking a stronger organizational and systemic focus. Due to its pragmatism, this approach can draw on the interest, support and advocacy for HL that is present within the healthcare sector. However, the pragmatic choice to limit the initiative at first instance to healthcare involves a risk of enhancing individual accountability for adverse health outcomes, and limits the possibility to operate cross-sectorally.

The third approach is to make *no governmental plan*, as in the Netherlands and Ireland. In this approach, authorities delegate the initiative to act on HL to civil society. It concurs with the conclusion of a European study (HEALIT4EU) that '*a policy does not seem to be a requirement for the development of programmes and activities on health literacy. […] Often both government and NGOs together initiate and conduct activities. In addition, national 'Networks' or National Working Groups on health literacy have an important advocacy role and act as a platform for exchange between research and practice*'.[55,56] However, for this approach to succeed, there is a need for an overarching structure that provides leadership with regard to HL and that helps bring the best out of each project. Such a structure can develop bottom-up from an adjoining sector, like the Irish NALA, or be steered top-down, by embedding all existing initiatives into a common program coordinated by a government-appointed structure, as in the Netherlands. A similar compromise between a government-led and NGO-led structure is the Austrian OEPGK, where representatives from federal and regional ministries and agencies collaborate with representatives from other sectors and with health insurance funds to select projects that have potential but for which financial means are lacking to support them.

While all of the approaches to develop HL policy and action plans described in this study have their own qualities and shortcomings, some of them probably correspond better to certain political or societal contexts. Policy makers should analyse their state structure and health system, and search for local 'pockets of excellence' or good practices, with a view to develop a well-planned, substantiated HL approach that best fits their country.

At present, health literacy appears to enjoy a lot of attention from policy makers at local, national and international levels. Spurred by international developments such as the recognition by the WHO (2017) and the United Nations (UN) that health literacy is a key determinant of health and an important condition to achieve the Sustainable Development Goals (SDGs), a growing number of countries recognizes low health literacy as a health problem, and is keen to develop policies and measures to address this problem. However, while this presents a unique momentum for improving the governance on health literacy, one should beware of unrealistic expectations with regard to what better ways to address health literacy can contribute to health. Although it is by now well established that low health literacy is associated with poor medication adherence, reduced self-care management, less favourable treatment outcomes, lower participation in screening and other preventive services, and less healthy behaviours, and that it can be considered a possible contributor to health inequalities,[57] addressing low health literacy should not be considered as an 'easy option' to alleviate health disparities. It does not preclude the need to tackle the root causes of health disparities and to implement profound changes at the political, economical and organizational levels to address these disparities. So, while addressing health literacy will help to improve individual health outcomes and most likely reduce health inequalities, actions to tackle low health literacy will remain ineffective if the social and structural determinants of health are not addressed simultaneously.

5 | CONCLUSION

This international comparison study identified several approaches, often influenced by contextual factors, healthcare reforms and existence of centers of expertise. Some governments developed full-fledged, standalone plans, while others developed broader plans covering the entire health and care sector. Some took a conceptually driven, high level approach. Others took a pragmatic approach. And some did not have a governmental plan at all. To identify the most appropriate approach, policy makers should analyse their state structure and health system, and search for local "pockets of excellence", to develop a well-planned, substantiated HL approach for their country.

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ETHICS STATEMENT

Since this study only analysed open access policy documents and did not collect any personal or sensitive information, research ethics approval had not to be obtained.

DATA AVAILABILITY STATEMENT

Data sharing not applicable – no new data generated.

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