

**European Health  
Management in Transition**



**Building and  
Improving Health  
Literacy in the  
'New Normal' of  
Health Care  
Frameworks and Actions**

**Federico Lega  
and Pia Kreutzer**

BUILDING AND  
IMPROVING HEALTH  
LITERACY IN THE 'NEW  
NORMAL' OF HEALTH  
CARE

# European Health Management in Transition

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Federico Lega, Full Professor of Health Management and Policy, Director of the Research and Executive Education Center in Health Administration, University of Milan

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# BUILDING AND IMPROVING HEALTH LITERACY IN THE 'NEW NORMAL' OF HEALTH CARE

Frameworks and Actions

BY

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INVESTOR IN PEOPLE

*This book is dedicated to all the passionate and dedicated health workers and health managers that make our lives safer and better.*

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# CONTENTS

<i>Abbreviations</i>	<i>ix</i>
<i>About the Authors</i>	<i>xi</i>
1. Health Literacy as a Key Factor in the ‘New Normal’ of Health Care Systems	1
2. Health Literacy: Definition and Background	11
3. Health Literacy Measurement, Assessment and Association	19
4. Health Literacy in the ‘New Normal’...and Opportunities for Technology	31
5. How to Improve Health Literacy	45
6. Clinical Pathways as a Management Tool to Enhance Health Literacy	61
7. Implications and Lessons for Health Policymakers and Health Managers	69
8. What We Should Know and Conclusions	91
<i>Annex A: Articles Included in the Systematic Review</i>	<i>95</i>
<i>References</i>	<i>137</i>
<i>Index</i>	<i>161</i>

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# ABBREVIATIONS

AI	Artificial Intelligence
AT	Austria
BG	Bulgaria
CVD	Cardiovascular Disease
CY	Republic of Cyprus
CZ	Czech Republic
DE	Germany
DK	Denmark
EBM	Evidence-Based Medicine
EE	Estonia
EHL	eHealth Literacy/Electronic Health Literacy
EL	Greece
ES	Spain
EU	European Union
FI	Finland
FR	France
HL	Health Literacy
HR	Croatia
HU	Hungary
IE	Ireland
IT	Italy
LE	Life Expectancy
LT	Lithuania
LU	Luxembourg
LV	Latvia
MOOC	Massive Open Online Course
MT	Malta
NCD	Non-Communicable Disease
NL	The Netherlands
OHC	Online Health Community
PCL	Patient-Centred Medication Labelling
PL	Poland

PP	Patient Portal
PSG	Patient Support Group
PT	Portugal
REALM	Rapid Estimate of Health Literacy in Medicine
RO	Romania
SE	Sweden
SI	Slovenia
SILS	Single Item Literacy Screener
SK	Slovakia
TOFHLA	Test of Functional Health Literacy in Adults
UK	United Kingdom
US	United States
WHO	World Health Organization

## ABOUT THE AUTHORS

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# HEALTH LITERACY AS A KEY FACTOR IN THE 'NEW NORMAL' OF HEALTH CARE SYSTEMS

*Health literacy is a stronger predictor of an individual's health status than income, employment status, education, and racial or ethnic group.*

–World Health Organization

*Literacy is a bridge from misery to hope. . .*

–Kofi Annan

'Health literacy is linked to literacy and entails people's knowledge, motivation and competences to access, understand, appraise and apply health information in order to make judgements and take decisions in everyday life concerning health care, disease prevention and health promotion to maintain or improve quality of life during the life course' (Sørensen et al., 2012, p. 83). This definition by the World Health Organization (WHO) is used throughout this book.

But why is health literacy (HL) important? Studied for decades, health literacy research has reached consensus on certain aspects. First, health literacy is a vital life skill for individuals. Health care in general, and primary care in particular, have begun to adopt a patient-centred approach

that empowers patients, helps to co-create and co-produce health services and co-create value. To do this, greater health literacy is essential. Second, health literacy is a public health imperative. As population health has gained wider attention, so, too, primary care and preventive medicine have gained importance. Nevertheless, many population health initiatives expect that people understand their circumstances, for which health literacy is a prerequisite. Third, health literacy is an integral part of social capital and indispensable for reducing health inequalities (Washington et al., 2018). Finally, it is also an economic issue. While low health literacy has been linked with underutilisation of health services and underdiagnosis, research has also revealed potential overutilisation of health services and overdiagnosis (Jessup & Buchbinder, 2018). Low health literacy has been associated with greater disease burden and worse health outcomes that absorb health care system resources (Kickbusch et al., 2006).

In brief, health literacy should be a top priority on the agenda of any health policy/system/agency. Here we argue that health literacy is a key element in building effective, sustainable and resilient health services. To better understand this point, we first need to examine the context of the ‘new normal’ in health care and its provision.

There is no academic definition of the ‘new normal’ in health care; however, it is very clear to practitioners when they realise that:

- the social media have gained pervasive influence on health and medical information (often misinformation)
- there is a need to co-produce and co-create health services with patients and caregivers who possess an adequate level of health literacy

- public agencies often fail to provide public health services and health education due to funding cuts (COVID-19 has demonstrated the effects)
- immigration has far-reaching consequences for public health/health behaviours
- young people are adopting unhealthy/risky habits (tobacco, alcohol and drug use)
- there is a need to better coordinate social and health care services for an ageing population with chronic conditions
- that there are limited financial resources
- patients expect to be informed, involved and treated as clients

Health care has become complex. The current dynamics are not conjunctural but rather structural... As such, they define the 'new normal'. A taxonomy of the changes characterising the 'new normal' in the health sector describes two clusters of structural change. The one concerns current developments, i.e. challenges due to:

#### 1. Shifts in epidemiology

- an ageing population with differentiated care needs
- frail patients (chronic, frequent service users, not self-sufficient) need an integrated continuum of care
- highly dependent, critical patients may not be so unstable as to require intensive care but rather an advanced care setting
- post-acute surgical patients need medical attention and integrated follow-up

- elderly patients with cognitive problems, complex social backgrounds
2. Technical and technological innovations in service delivery
    - freestanding surgery, mini-invasive techniques, robotics and procedures (e.g. day surgery, one-day surgery, week surgery) require greater self-care by patients
    - increased risk of turf wars due to the overlapping between areas in medical, surgical and interventional diagnostics (cardiovascular, neuroscience, oncology)
  3. Expectations of improved flow and quality of care
    - building patient-centred hospitals designed around patient needs
    - greater efficiency and productivity, and specific pathways for urgent and elective care
    - multidisciplinary teamwork
  4. Outcome accountability
    - tracked attention to evidence-based medicine and clinical governance
    - patient-reported experience measures and patient-reported outcome measures (PREMs and PROMs) taken into account, with a greater role for patients

These challenges make up only a subset of what health care managers really handle. The second cluster comprises the reasons why health care is so complex and health care

organisations so challenging to manage: a prototype of the volatile, uncertain, complex ambiguous (VUCA) environment.

Health care systems are entering a new normality not merely in the ways they evolve but how revolution can drastically change them. Disruptive innovation is fast and furious: artificial intelligence, robots, precision medicine, regenerative medicine. Technology and algorithms are set to govern health care procedures. Financial struggles are common to all countries, even the richest. In many places, health care professionals are facing a loss in status and role, and there is a widespread shortage of doctors in many developed and developing countries. New business models for low-cost or low-price health care, focussed hospitals and medical tourism have entered the health care marketplace.

In this evolving and revolutionary context, new paradigms are needed to cope with this new normality. A paradigm shift that can increase the chance to meet quality and sustainability challenges.

One major effort is to implement the logic of population health management. This implies managing health and wellness proactively, with a focus on prevention, risk factor reduction and management of chronic conditions, while supporting the co-creation and co-production of health care services. Health literacy regards not only individuals concerned with their own or their family's health but also organisations, public health systems and society as a whole. Bitzer and Sørensen (2018) argue, for example, that systems, institutions and other health organisations must be 'responsive', i.e. they must provide health information, resources, support and environments in such a way that they are equally accessible and useable by people with different levels of health literacy. The societal importance of health literacy concerns prevention and adequate treatment. Since a health literate person is more likely to maintain good health status, primary prevention is

involved. But health literacy is also vital in secondary prevention. Ratzan and Parker (2000) mention that ineffective communication between health care providers and patients could cause medical errors due to misunderstanding or misinformation about treatment and self-care instructions.

In this light, fostering health literacy poses a challenge for patients and health systems and organisations alike. If we really want to change the dominant paradigm in care provision from compliance to concordance (where the health care professional and the patient build an alliance with one another), and from empowerment to self-management and co-production, we will need to raise the level of health literacy across the population. Investment in health literacy brings returns, since quality, efficacy and sustainability have a positive correlation with co-production and concordance. Furthermore, better informed patients may be more difficult to manage and keener to spot and assess deficiencies in health care delivery. Ultimately, such health-user pressure could push health care systems and professionals towards a patient-centred organisation that is expected and desired.

Moreover, population health management is often linked to the Triple Aim notion: an approach developed by the Institute for Healthcare Improvement (IHI) to optimise health system performance (Berwick et al., 2008). According to the IHI, the goal of the Triple Aim is to ‘improve the patient care experience, improve the health of a population, and reduce per capita health care costs’. It is a single strategy with three key goals.

The recently introduced fourth goal – to improve clinical experience – has led to the creation of the Quadruple Aim (Bodenheimer & Sinsky, 2014). The idea is that, without an improved clinical experience on the provider side, the three other patient-centric aspects won’t reach their full potential. The four components of this framework, around which all

European countries are developing (or should develop) their current strategic directions of health policy, are:

1. **Improved patient experience.** Improving the patient experience aims to enhance the quality of care that patients receive, with a greater focus on individuals and their families. The focus is on safety, effectiveness, patient-centredness, timeliness, efficiency and equity. This means adopting the logics of business modelling in health care to design service delivery. Plus, attention is devoted to health literacy, as more educated patients can be expected to manage their health more effectively.
2. **Better Outcomes.** With the Triple Aim comes the goal of improving the health of the overall population by measuring outcomes, increasing transparency and incentivising by pay-for-performance.
3. **Lower Costs.** The Triple Aim intends to reduce the per capita cost of health care. Keeping this aspect linked to improved patient experience and improving the health of populations ensures that when costs are driven down, the quality of care isn't diminished.
4. **Improved Clinical Experience.** The aim is to create conditions and motivation for the most effective delivery of health services. It's the responsibility of managers. The pressure on caregivers is immense, leading to unwanted outcomes that can reduce the quality of the care they provide. Research has shown a correlation between low staff engagement and burnout and low patient satisfaction, poor health outcomes and high costs – which contrast the Triple Aim approach. To combat this, an improved clinical experience should be included in the Triple Aim, updating it to the Quadruple Aim. The Quadruple Aim is the

framework that guides the direction that health care systems – including patients and providers – should pursue. As Rome was not built in a day, the change will not happen overnight nor will improvement in health care system performance. It's a long-term objective that can be reached through short-term goals (and objectives) set by single providers and agencies.

Several issues need to be addressed by health policymakers and managers. If patients are at the centre, how can the shift from compliance to concordance be made? How can the co-creation and the co-production of services be developed? Empowerment entails not only qualification but also engagement and co-responsibility. Chronic care models are evolving in population health care management. But what exactly is happening? Attention should be directed towards risk factors and prevention. How can this be organised? How can individuals be more informed of their risk factors and lifestyles?

There are many questions and challenges but few certainties. One of which is that health literacy is fundamental for health systems to meet the changes ahead and adopt to new paradigm shifts. There are myriad reasons why we should care about health literacy. But before discussing each in more detail, we first need to understand what we mean when we talk about health literacy. We will then situate health literacy in the context of the 'new normal' of health care and its implications.

The next chapter (Chapter 2) gives a short history and background of health literacy, followed by definitions (Chapter 3). The relevance and correlations of health literacy are then analysed and the methods to assess and measure it.

Finally, health literacy will be contextualised in the 'new normal' and interventions to improve it will be outlined, as