Health Literacy in Ireland:

Benchmarking the Present State of the Art and Examining Future Challenges and Opportunities

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Health literacy is still a new concept in Ireland. Yet NALA published its first report on it almost ten years ago. Indeed, NALA has been the main driver in the area of health literacy over that time, though its efforts to make health literacy a priority for public policy have been aided by the Health Promotion department of the HSE and more recently the work organisations such as MSD and UCD. Various people in these agencies have been to the fore, and their efforts will be highlighted in this paper. The main aim of this piece is to act as a milestone position paper on the development of health literacy in Ireland. In doing so, the paper will summarise the work done to date by NALA and others, highlighting specific insights. It will give an up to date assessment of the current state of play and point to future directions.

In terms of structure, the paper starts by outlining the emergence of health literacy internationally and the diffusion of this focus to the Irish context, starting with the literacy focus and moving to health literacy. Expert commentary on definitions of health literacy, international research, measurement and policies are evaluated. There is also a discussion of the historical development of health literacy in Ireland, drawing on important policy publications by NALA and other significant research work done elsewhere, intrinsic to this process. As part of the brief informing the paper, key Irish stakeholders who have driven health literacy in Ireland have been interviewed.

A purposive sample was used to identify and interview four key people involved in health literacy in Ireland. These were:

Ms. Inez Bailey- Director of the National Adult Literacy Agency

Sarah O'Brien- Project Officer, Health Promotion Department, HSE

Ms. Ciara O'Rourke- External Affairs Director MSD

Dr. Gerardine Doyle- Director of Health Literacy PhD Programme, UCD

The paper provides the commentary from these interviewees in text boxes as it develops, which offer specific commentary on Ireland, relevant to the specific theme being discussed in the text. The paper will inform an assessment of how far health literacy has developed in Ireland and how far this judgement accords with the aims, objectives and stated ambitions within NALA's vision, derived from its published policy. Indeed the paper will also assess how far health literacy has developed in Ireland compared to countries such as the US or Canada, building on the work of international experts and organisations.

The Challenge of Health Literacy

The paper traces the historical developments in the area of health literacy in Ireland. This is done through detailing the pioneering work done by NALA. Links are developed to specific Irish government policy documents of relevance also. Discussion of academic writing on health literacy internationally is provided. The aim is to trace the development of health literacy in Ireland from its foundations and provide a current assessment of its status. (See Appendix 1)

Health Literacy in Ireland: How Far has it Come?

According to Inez Bailey, in the international context of health literacy, some useful work has been provided by NALA and others, but overall Ireland is not a leader in the area. She believes that Ireland is lagging behind in the macro policy environment. For example, Ireland doesn't have any corresponding example of a policy champion in the area of health literacy such as US Surgeon General Admiral Moritsugu. Ireland does have some evidence of success at a practical level. Contrarily, Canada has done far more work on the macro policy level but is weak on the practical application of health literacy. Overall, Inez is clear that there is no macro policy framework for health policy or national policy champions in Ireland, unlike the USA.

MSD's Ciara O'Rourke believes that NALA has exerted a decisive impact in driving the area of health literacy in public policy in Ireland. However, she is of the view that NALA needs to have more people employed to push this area forward in to the future. At present, she points out that NALA only has one person appointed part-time in the area of health literacy, even though it is the only voluntary agency in the country dealing with health literacy.

UCD's Gerardine Doyle is of the view that despite NALA's Health Literacy Audit of HealthCare Settings tool, there is very little work being done by GPs and health professionals. Even in the USA, where health literacy is far more developed, very few of the practitioners make use of teachback and talkback. She believes that NALA has taken an important lead in developing health literacy teaching materials for family literacy courses and the health literacy audit tool. It is her view that hospital managers should take charge of rolling out health literacy audits and other interventions. She is strongly supportive of the performance of the NALA/MSD awards in promoting public awareness of health literacy.

The Beginning: Literacy

NALA has been by far the biggest driver in the area of health literacy in Ireland. The National Adult Literacy Agency (NALA) was set up a group of volunteers in Ireland in 1980. Since then, with funding from the Department of Education and Skills and in partnership with the Vocational Educational Committee (VEC), NALA has been to the fore in highlighting, researching and providing adult literacy courses in the country.

International Adult Literacy Survey 1997

A defining moment in the work of NALA was the publication of the International Adult Literacy Survey (IALS) in 1997. The survey was conducted by the OECD and the results for Ireland derive from 1995. The results of this survey for Ireland were poor. The survey was hugely significant for the area of literacy but also provided a catalyst for an enquiry into health literacy in Ireland, culminating in a NALA published research report entitled, Health Literacy: Policy and Strategy in 2002.

The IALS survey utilised a five point scale for measuring literacy, which included a measurement of both reading and numeracy proficiency. The survey tested people's reading and numeracy in tasks common in everyday life, such as reading a train timetable or following the instructions for taking Aspirin. On the five point scale, IALS considered 'level 3 [to be] the minimum level needed to actively engage in Irish society'(Lynch 2009:52). The results showed that 25% of the Irish population were below level one and 30% below level two with the defined thresholds as follows:

- Level one " indicates very low literacy skills, where the individual may, for example, have difficulty identifying the correct amount of medicine to give a child from the information found on the package". (NALA 2002: 8)
- Level two: "Those at level two have been identified by the survey as people who can only deal with material that is simple, clearly laid out and in which tasks involved are not too complex."(NALA 2002: 8)

As a consequence, the IALS (1997) survey found that 53% of the Irish population were not 'functionally literate'.

From Literacy to Health Literacy

Having discussed the concept of literacy, the different levels, and the concept of 'functional literacy' and how low levels of literacy can prevent people from completing simple day-to-day tasks, an extension of this challenge is the clear link between literacy and health literacy. In order to explore this link, we must first define by what we mean by health literacy. There are a number of different definitions spanning the international literature. The three most useful definitions selected for this paper are:

1. "Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions". (US Department of Health and Human Services 2010: 2.1)

   This definition has now been accepted by the US Institute of Medicine, having provided an earlier definition of health literacy in 2004:

2. "Health literacy emerges when the expectations, preferences and skills of individuals seeking health information and services meet the expectations, preferences and skills of those providing information and services". (IOM 2004)
3. "Health literacy is the ability to make sound health decisions in the context of everyday life-at home, in the community, at the workplace, the health care system, the market place and the political arena. It is a critical empowerment strategy to increase people's control over their health, the ability to seek out information and their ability to take responsibility" (Kickbusch 2005: 32).

Definitions of Health literacy

Inez Bailey does not favour the Institute of Medicine's definition of health literacy. The definition of the American Medical Association is superior: 'health literacy is a consternation of skills, including the ability to perform basic reading and numerical tasks to function in a healthcare environment'. There has been a lot of debate on health literacy definitions and this one is a functional definition. However, there are definitions from 'the right and the left' in the area of health literacy, according to Inez Bailey. NALA adopts a wide definition of health literacy.

Gerardine Doyle does not believe that the Institute of Medicine's definition of health literacy is the best available. She believes that an array of different definitions needs to be used, pointing out that the EU Health Literacy Survey takes a number of definitions together.

Sarah O'Brien believes that the IOM definition is helpful in clearly showing that work is needed on both sides to provide a level playing field and that literacy isn't the sole responsibility of the individual. It allows for continuous improvement. However, some may find it unhelpful in that it doesn't provide a concrete definition.

Intrinsic to all these definitions is the need for the health consumer to (a) clearly understand information related to her health. She needs to read and understand any terminology used to diagnose or describe her illness for example, or any set of instructions on managing a health problem. In addition to understanding the written form of communication, (b) verbal communication of the health issue needs to be expressed clearly and made accessible to the patient. She needs to clearly understand what type of treatment she will be undergoing and she needs to be empowered to process this often complex information to make informed choices. This can only be done by clear verbal explanation.

However, the problem arises when the patient who possesses only a relatively low literacy level (a) meets health information which is written at a relatively high level or (b) which is explained in a language which is inaccessible, at a level which the patient does not encounter in her daily life. When both events occur, the patient's understanding of the health information and decisions affecting her is significantly compromised. Ultimately, the health of the patient is compromised or life put at risk. In these cases, which are numerous, low basic literacy gives way to low health literacy. In the words of the USA Joint Commission White Paper on Health Literacy (2007):

> *" When literacy collides with health care, the issue of health literacy-defined as the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions-begins to cast a long patient safety shadow"(Joint Commission 2007: 4).*

An issue for everyone

Nonetheless, even in cases where an individual possesses a high level of literacy, the level of health literacy may still be low. The research discussed below demonstrates that a person's ability to understand and process health information can become strongly circumscribed by inhibiting factors which have to do with the way health information is written and/or the way it is communicated to her by health professionals. The fact that low levels of health literacy can exist independently of low basic literacy levels has been made by many, particularly Don Nutbeam:

> *"Even where a person has advanced literacy skills, their ability to obtain, understand and apply health information in a specific health context can be poor" (Nutbeam 2010:4).*

Benefits aimed at improving health literacy for those with low literacy and advanced literacy, can significantly improve health outcomes according to Nutbeam. This can best be done by "actively involving patients in their own care"(Nutbeam 2010:4). Nutbeam stresses that improved health literacy can have wider outcomes also for the patient and society:

- Increased use of preventative practices
- More appropriate use of health services
- Reduced unplanned hospital admissions
- Reduced healthcare costs

(Nutbeam 2010:4).

Health Literacy: Inhibiting Factors

This section examines the factors that lie behind health literacy problems. It will deal with the disjunction between literacy levels and reading materials in the first instance. It will move on to look at communication barriers between patients and medical professionals which exacerbate and further create health literacy difficulties.

Literacy & Standards of Medical Writing

Low levels of health literacy are a problem found in all countries in the western world. A Canadian study by the Centre for Literacy of Quebec (2001) found that 48% of Canadians had levels of literacy below level three in the IALS (1997) survey; this was mirrored in corresponding figures of 45% in England; 51% in the USA and 52% in France.

However, the Canadian study states that most health care information is written at a level corresponding to 10th grade or higher in the US and Canada. This is higher than the average level for the population and completely removed from the 45-55% of the population who are reading at levels 1 or 2 as categorized in the IALS (1997) study. Quite obviously, this means that at least half, if not more of population will find it difficult if not impossible to develop high levels of health literacy if they cannot read the health information in the first instance.

The implications of Irish and International research on the links between literacy and health literacy, based on inaccessible reading material, have been clearly stated by NALA in a recent report:

> *"Hundreds of studies in the USA focusing on the assessment of health materials indicate that the reading level of most health materials exceeds the reading ability of the people for whom they were designed (Rudd 2000). International research shows us that there is a mismatch between the literacy demands of reading materials in healthcare settings and the reading materials of the general public"(NALA 2009:16).*

Doak et al (1996) explain that the average reading level of US citizens is at 8th or 9th grade, which is somewhere between levels 2 and 3 in the IALS study and that 20% are reading at the fifth grade level, about level 1 in IALS. In the following ten years, there has been very little change in these figures, as illustrated by the figures for the USA form the National Center for Education Statistics for 2006:

> *"53% of US adults have health literacy scores in the intermediate range, a category indicating needed skill building. Fourteen per cent of adults scored below basic level; an addition 22% scored at the basic level and 12% scored in the proficient level"(Rudd 2007: S16).*

In 2010 NALA studied a sample of Irish health leaflets using the National Framework of Qualifications levels and found leaflets ranged from level 3 to level 5. The report recommended that leaflets should be pitched at level 2 so as to enable people to read and understand the information.

Ireland's first health literacy study

NALA has been acutely aware of the health literacy problem in Ireland and approached the Department of Health in 2001 to fund the first health literacy study in Ireland. The Department funded a study and NALA's Health Literacy and Policy Report was published in 2002. This report utilising a qualitative research methodology, examined the views of 78 adults with weak literacy skills in focus groups regarding their ability to understand and process health information. The study detected widespread difficulty among participants in reading hospital signs; understanding basic health information and difficulty in filling out forms. A sample of the findings is illustrative:

One mother, who was unaware of the asthma services that were available to her free of charge on the medical card to treat her asthmatic daughter stated:

> *"It makes me feel powerless to help my child"(NALA 2002: 27).*

Most women found the medical terms used in public health leaflets as akin to 'using a foreign language' with one woman asking why the leaflet could not have detailed the word 'eyes' next to 'ophthalmic' (NALA 2002: 28).

These findings were mirrored in a US report by Davis et al (2002) where many patients with low health literacy did not understand the meaning of words such as: 'polyp' or 'tumour' or 'lesion'.

Filling out Forms

There was a huge unease amongst the participants about filling out forms and feelings of helplessness, due to poor levels of health literacy. This is obvious in comments such as:

> *"I don't know what I'm doing".*

Exactly the same problem was found in the US where it was found that 44% of patients did not understand the medical operation they were consenting to on the informed consent form (National Quality Forum 2005).

> *"I feel embarrassed when I can't read or write, there is no privacy in this" (NALA 2002).*

OECD IALS Irish Results (1997)

For Inez Bailey, the IALS survey has been a very significant spur to health literacy recognition and development in Ireland. The IALS survey (1997) was the only adult literacy survey in Ireland ever. The fact that the OECD itself and Canada, where the instrument was developed, were both health literacy leaders very much helped. Findings such as 25% not knowing how to properly take their medication were hard-hitting. Policy makers found it quite shocking that health literacy challenges of such magnitude were present. This finding broke new ground in the literacy area, because it went beyond looking at literacy simply as a deficiency in reading or writing. It showed that even people who can read may still have a problem fully understanding the text. Significantly, the IALS survey did put health literacy on the policy landscape by using practical examples showing the dangers of ignoring health literacy. The survey also boosted research in the area, according to Inez Bailey. The survey shockingly illustrated glaring levels of socio-economic disadvantage that co-existed with low literacy levels for large sections of society; which also impacted on their employment attainment and workplace performance. Inez also highlighted the increased levels of health literacy with age, where the figure for those with health literacy difficulties rises from one in four to one in two. This negatively impacts on their ability to manage their health.

Ciara O'Rourke also views the 1997 OECD literacy research as having been a very significant development, as it gave a platform on which health literacy could develop. Nonetheless, she is very clear that health literacy is a much broader concept than the literacy focus of the OECD report. Her view is that health literacy is more centrally focused on 'understanding' health information, rather simply reading it. She gives the example of a person being able to read an asthma leaflet 'perfectly well' but the question is 'do I understand it?'. The ability to understand signage in hospitals is also at the centre of health literacy, if something is not written in 'plain English', it can be read, but may not be understood.

Gerardine Doyle is of the view that the OECD Literacy report is dated. It focused on reading and a specific health literacy report is needed. Most of the US research is on literacy itself as regards health literacy. Her view is that the EU approach is broader and also involves the empowerment of individuals to make healthy decisions and live more healthily.

According to Sarah O'Brien, the OECD (1997) survey has been useful, particularly in establishing 'functional literacy' point from a health practitioner perspective. The IALS results when used by Department of Health refer to the Level 1 results only however, and don't take on board the 'functional literacy' issue which would indicate that half of the population would experience 'health literacy' difficulties.

The role of Plain English

As an obvious logical development, 'Plain English' has been promoted in health settings, most notably through the National Literacy and Health Programme of the Canadian Public Health Association (CPHA). Campaigning has begun to ensure medical professionals write their materials and instructions to patients in a simple and easy to understand way. For example, as far back as 1999 the CPHA introduced its Directory of Plain Language Health Information that gives guidelines on how to assess materials (the S.M.O.G Readability Formula or Simple Measure of Gobbledegook)"(CLQ 2001: 10).

In addition to empowerment benefits to the patient and the ensuing health benefits, more effective and clearly understood written instructions can also have economic benefits:

> *"Studies in the United States and Britain have shown that plain language writing saves money. Many writers offer concrete and useful tips on how to present information, how to design visuals and how to choose appropriate language.....the consensus is that to be effective, patient education materials should include short and simple information, be written in simple language, contain culturally sensitive graphics and focus on the desired behaviour of the patient (Mayeaux, 1996)" (CLQ 2010: 11).*

Rudd (2007:S17) has called for plain English in charts and other materials for patients. Her belief is that these materials need to be designed not just in plain English, but also have the needs of the user in mind:

> *"Materials designed from the perspective of the user, based on clear understandings of the purpose the materials serve and the tasks adults need to undertake, could lessen the burden on the user".*

NALA established its plain English service in 1998 and the first national information leaflet to be edited was commissioned by the Eurochangeover Board. Since 1998 NALA has trained up to 300 health practitioners in PE and edited many national health leaflets. In recent years, NALA has been to the fore in attempting to promote 'plain English' as an organisational imperative amongst medical professionals, within hospitals and GP surgeries in particular. In 2009, NALA and the HSE published its Literacy Audit for Healthcare settings providing a manual to health care managers on how they can lead this development within their organisation. In 2011 the ICGP included this publication as part of their Professional Competency Toolkit.

NALA's Work in Health Literacy & the Role of MSD

Inez Bailey - Director of NALA

The work NALA has done with MSD, most notably the MSD Awards, has increased public awareness and attracted media coverage, according to Inez Bailey. The NALA 'high level' work has been brought to a wider audience through the use of the awards. These fitted in well to the 'culture of awards' in the corporate and public sectors. The awards gave groups an greatly helped in 'showcasing' some of the excellent health literacy projects across the wider population. NALA does not have the resources to make health literacy a bigger part of its wider work. It is possible however for NALA to design learning programmes for individuals who would like to learn more on an illness they are suffering from and how it should be managed. NALA builds 'the learning programme around the individual'. There is need to promote health literacy as an area in its own right, which differs from the current overall 'basic literacy service' that exists.

A Wider Role for NALA?

Sarah O'Brien, Health Promotion Unit, HSE

Sarah O'Brien is very positive about the work of NALA in the health literacy area, particularly its efforts to upskill health practitioners. However, she believes that the approach to health literacy should be broader and deeper than Plain English and Literacy Awareness. She believes that NALA's teaching materials in the area of health literacy are very valuable, particularly for families. She believes that NALA should have a bigger capacity building and ownership focus within its rolling out of the health service audit tool, rather than simply providing a service. She is also very positive about the MSD Health Literacy Awards which are valuable in raising awareness with a limited audience, mainly consisting of health professionals. The awards are also good for identifying examples of excellence. However, she isn't sure how 'transferable' these are. She also believes that the MSD Crystal Clear healthcare awards submissions tend to be very focused on oral/written communication and consequently is not sure how valuable these are in terms of sustainable behaviour change. She believes instead that 'they could be developed to address this issue more'.

Health Literacy and Health Outcomes

There is a clear link between poor health outcomes and literacy, with low health literacy being the mediating factor. Firstly, it is beyond doubt that health inequalities arise due to structured income and wealth inequalities in the system. This was pointed out in two seminal reports in the UK in the 1980s (The Black and Whitehead Reports). It has been documented in Ireland by the Institute of Public Health (2001). In the past two years, the seminal and groundbreaking book by Richard Wilkinson and Kate Pickett (2009) has set the link between inequality and ill health in stone on a global level.

Essentially, individuals and families living in poor quality housing with few resources and suffering from social deprivation are firmly rooted within the lowest social classes in society. These individuals and families in turn are likely to be less-well educated (Smyth 2000; Whelan 2007). Those in lower social classes have lower literacy scores, as has been proved in literacy surveys for Ireland:

> *"Reading achievement was related to social class in 2003 and in 2006. In 2006, the mean score of children from the highest social class category was much higher (551.2) than the means score of children in the lowest social class category (490.2)"(OECD-Pisa 2006).*

So, in overall terms, those in lower social classes will have lower levels of health and literacy, simply because they are poorer, before we even consider the impact of health literacy. These are sometimes referred to as 'indirect effects' (Perrin 1998). The double-whammy occurs when this low literacy affects the individual's ability to read important health information or understand instructions. Studies done by Perrin (1998) for the Ontario Public Health Association showed that:

- Low literacy individuals have difficulty reading health information and that this can sometimes lead them to making mistakes in taking medication.
- They find it hard to 'comply with health directions' (e.g a diabetic following prescribed treatment).
- May have a difficulty understanding health and safety instructions.
- Persons with low literacy cannot read written instructions for preventative care, self-care and follow-up care after an illness or an injury.
- People with low literacy skills have problems understanding appointment slips, informed consent forms, discharge information and oral instructions.

(Centre for Literacy of Quebec 2001:5)

We can deduce then that the original low literacy is effecting the person's ability to make the 'sound health decisions' or 'appropriate health decisions' as described in the defining features of health literacy in the definitions by the US Department of Health and Human Services (2010) and Kickbusch (2005) respectively. The ensuing unsound

health decisions will put the person's health at risk. Clearly, low health literacy will lead to poorer health outcomes. The strong link between health literacy and improved health outcomes offers a strong public health rationale for establishing health literacy as a mainstream public health goal. This is clearly stated in the US Department of Health and Human Services-Expert Panel Report on 'Improving Health Literacy for Adults' (2009:1):

"Limited health literacy has been linked to increased health disparities, poor health outcomes, increased use of health services, and several healthcare safety issues, including medical and medication errors. Improving health literacy for all Americans has been identified as one of the 20 necessary actions to improve health care quality on a national scale".

Benefits of Health Literacy & Health Outcomes

The most significant benefit in improving health literacy is its improvement of health outcomes, according to Inez Bailey of NALA. The studies that show the benefits to physical health are the most significant but there are others in the 'softer areas' which also show benefits: Inez highlights improvements in emotional health and stress reduction attendant on the individual's improved self-health management. As an illustration, she points to data showing that those with low health literacy having on average ten years less of life than the average for the population. Also, developing an understanding of health literacy can improve chronic conditions such as diabetes and asthma in Inez's view. Further, there is too much of a focus on the educational status basis of poor health in the research which may be hampering policy proposals. The solution to improving an individual's health literacy should be firmly based on developing competencies for people through educational interventions across the life course, which would also benefit workforce participation and general living patterns. Her views indicate that health literacy interventions in the different settings are what is needed, which is based on establishing the level of literacy people actually have, as was done in the OECD Survey, not educational status. As a case in point, she compares adults in their 40s having to become competent in computer applications today through self-directed learning, which wasn't taught in their school or college experience. The point is that new competences have to be learned all the time and that health practitioner's improved communication would greatly improve health literacy learning outcomes for people in this way.

Ciara O'Rourke is also of the view that once a patient is empowered through an improvement in health literacy, then they can be very clear about the need to take prescribed medication, given their understanding that it is geared to ▶

- improving that person's health outcomes. Also, 'if a person understands why they have heart disease, they are much more likely to start exercising and eating more healthily and taking their medication....' Simply put, 'the improvement in health outcomes is the ultimate goal of health literacy'.

  For Gerardine Doyle, the single biggest benefit arising from improved health literacy is the improvement of health outcomes. There are cost savings that can be made as a result of improved health literacy in the health system. People can have more control over their lives, can live healthier and make more informed choices about their health e.g. diabetes prevention; asthma inhalers. She also believes that an improvement in population health literacy can significantly improve the whole area of health promotion. In this context, she points out that there are several groups at the moment using health literacy as a tool for health promotion and delivering seminars etc. One is the Arthritis Society of Ireland.

  Sarah O'Brien believes that the main benefit of health literacy is that it can promote better health, which ultimately leads to improved health outcomes. She believes that health promotion is integral to addressing health literacy in its broadest sense. Health promotion takes a settings approach within Health Service and Community & Education involving areas such as the SPHE curriculum & health promoting schools, all of which improves health literacy.

  She is keen to point to the need to harness community education and development to grow health literacy in Ireland. Within a community setting, health literacy can be integrated into areas such as: community development work, personal skills development (Healthy Food Made Easy, Expert Diabetes programme, Family Communications & Self-esteem, Smoking Cessation Groups etc). All of these are promoting health and health literacy also. Further examples include the provision of accessible information on positive lifestyle behaviours whether through print, online materials or public awareness/social marketing campaigns.

Poor Communication by Health Practitioners

However difficulties in achieving high levels of health literacy go beyond the written word. In the past five years, there has been a far greater body of work written which also demand a significant improvement in the way health professionals communicate with clients.

NALA (2002) offered some of the early work in this area, detailing the disempowering affect on clients who fail to understand the details of verbal exchanges with health care professionals. The report detailed clear breakdown in communication between patients and medical professionals:

> *"One young woman reported being mistaken as the mother of her two-year-old sister by a hospital nurse. The health professional asked her to stay in hospital with her infant sister assuming she was her mother. This is an example of poor communication which had the potential to be problematic"(NALA 2002: 28).*

Another woman who had undergone surgery did not know what part of her body had been removed in an operation. Others complained that GPs spoke too quickly for them to understand the information.

Internationally, a very strong impetus in the area of improved communication by health care professionals, and containing a strong statement that this would improve patient safety, came in the report of the Joint Commission in the USA (2007) in a report comprehensive report entitled: " What Did the Doctor Say?": Improving Health Literacy to Protect Patient Safety.

The Joint Commission (2007:11) report highlights the fact that in the US "misadventures in the administration of drugs are the most common category of medical error". It concludes that poor communication between patient and doctor is a significant factor. This fact is also borne out by an Institute of Medicine report (IOM 2006) which, according to the Joint Commission, concluded that:

> *"Current methods of communicating about medications with patients are inadequate and contribute to incidences of medication errors"(Joint Commission 2007: 11).*

As a consequence, the Joint Commission recommends inter alia that medical personnel should:

- Practice 'read back' or 'teach back' with their colleagues as well as their patients. These are techniques whereby the doctor asks the patient/colleague to read back what the doctor has read or explain to the doctor in his own words the explanation/instructions that the doctor has given. This establishes whether or not there is a clear understanding or reading ability on the side of the patient.

- Test the patients understanding by asking them open-ended questions to check out his understanding of what is being discussed.
- Provide easy to understand information which puts the patient at the centre.
- The report acknowledges that some progress has been made by the American Medical Association to date in using these and other methods through the introduction of an AMA Toolkit which specifies new methodologies for doctors to radically improve the communication experience with their patients.

Diverse cultures

The issue of ensuring a high level of health literacy between practitioners and different ethnic groups/cultures is another area that needs to be significantly improved according to the report by the Joint Commission. Doctors need to confirm that those from different language and cultural backgrounds understand what is being communicated to them and any written instructions. Medical practitioners need to go beyond the level of translation to ensure that information is clearly understood. The report also requires interpreters and medical personnel to be educated in the cultural norms and practices of different patient groups through the achievement of cultural competencies.

The Irish 2008 National Intercultural Health Strategy recognised that a greater emphasis on visual and spoken messages is required. It also advocated the provision of information in clear understandable language to facilitate access to health services for people from minority ethnic groups as well as those with low literacy skills.

NALA/HSE Health Literacy Audit

Following the publication of Audits in Canada and the USA, the HSE funded the development of a communication guide for its staff to identify literacy barriers in their work and practices. An accompanying health literacy awareness DVD was also produced at this time: Better health, Better communication.

The NALA/HSE (2009) Literacy Audit for Health Care Settings is a practical manual aimed at health care providers to improve their communication with patients. The report highlights that healthcare settings, more than many other organisations rely primarily on written forms of communication and more commonly use verbal communication as the most common form. The report argues for more interaction between patients and medical personnel and the use of interactive techniques to facilitate this process.

In 2011 the HSE also published a Plain Language Style Guide for documents which complements the NALA/HSE Audit (2009).
http://www.healthpromotion.ie/health/health_literacy

New Innovations, Accreditation and Partnerships

The work of NALA in Ireland, in particular the clear innovatory methods it suggests to improve health literacy in health care settings, have been given significantly more attention in the United States than in Ireland. The link between improved health outcomes arising from improved health literacy has been amplified to a far greater extent in the US by bodies such as the Institute of Medicine, the American Medical Association and the Joint Commission and in Canada by the Canadian Public Health Organisation. New partnerships have emerged also and there is a greater emphasis on building health literacy techniques in to the accreditation of medical personnel.

Health Literacy Partnerships

Significantly, given that NALA has been involved in developing literacy partnerships with communities of learners and practitioners for decades in Ireland, the Joint Commission (2007) policy White Paper advocates learning partnerships such as these in order to improve health literacy in the USA. Importantly, these partnerships should also include health practitioners and involve all relevant parties in the insertion of health literacy in to the health curricula. This is one of the central recommendations of the report. In order to improve communication between patients and health professionals and the health literacy of both parties in their common interest, policy should:

"Encourage partnerships among adult educators, adult learners and health professionals to develop health-related curricula in adult learning programs, and conversely, to assist in the design of patient-centred health care services and interventions"(Joint Commission 2007: 9). A case study of how this works in practice is the Iowa Health Literacy Collaborative which was set up in 2003 and which is supported by the American Medical Association.

Healthcare Accreditation

In the area of accreditation, the report points to two significant developments: the United States Medical Licensing Examination (USMLE) tests medical students in their third and fourth years on their communication skills with patients. These skills are also tested on actual hospital residents under the competencies laid down by the Accreditation Council for Graduate Medical Education (ACGME) and by the American Board of Medical Specialities (ABMS). In addition, the Institute of Medicine, in its report entitled Health Professions Education: A Bridge to Quality (IOM 2003: 3) is now demanding five new skills for all health care practitioners:

"All health professionals should be educated to deliver: 1. Patient-centred. 2. As members of an interdisciplinary team. 3. Emphasizing evidence-based practice. 4. Quality improvement approaches. 5. Informatics".

Community Health Education

Other community education-health personnel-patient partnerships such as the automated diabetes management helpline run out of San Francisco General hospital or the Reach out and Read (ROR) programme which started as far back as 1989 in the Boston Medical Centre, trains doctors and nurses on the importance of reading to children from poor backgrounds (Joint Commission 2007). Even more significant is the fact that the US National Centre for the Study of Adult Learning and Literacy (NCSALL) developed health literacy materials and curricula, specifically designed for various areas of the health system (Rudd 2004). Private health care insurance agencies in the US, such as Blue Shield are also driving health literacy in order to improve hospital performance, where physicians are encouraged to participate in E-learning demonstrations to improve interaction with patients (Misky 2005). In an effort to drive down claims, Pro-Mutual of Massachusetts has been providing four month training programmes to doctors, aimed at improving their communication with patients. (Hollmer 2005)

From the point of view of patients with low literacy/low health literacy, the focus has started to move towards the learner and particularly creating a conducive and safe environment for patients as learners. Many approaches in this area utilise 'participatory' learning methododologies, which are firmly rooted in the work of Brazilian educator, Paulo Friere. These seek to empower individuals to work on their literacy, understand health care and also the wider political structures in society that disempower them. The work of Hohn (1998) in Massachusetts is firmly located within this tradition:

> *"The Hohn study focused on the empowerment of low literacy individuals. Participatory health education goes beyond having a patient understand information on a disease or taking prescribed medication. The goal is to empower users of the health systems so they may gain control over their own lives in the context of participating with others to change their social and political realities"(CLQ 2001: 12).*

Participatory health education programmes have sprung up in Canada, working from within this model. A further and well-developed approach has been put forward by the Australian expert on health literacy, Don Nutbeam. Nutbeam posits three levels of health literacy: Functional; Interactive and Critical. He argues that community –based educational approaches should empower people to read and understand medical data as a first step and this is a since qua non. This functional health literacy should move on to allowing patients learn independently and develop the human resource and organisational capacity to take control of health programs and education for themselves. Ultimately, in the move to critical health literacy, these groups address deeper issues such as the structural basis for health inequalities, low literacy and other barriers. In order to fulfil these objectives, an increased proliferation of partnerships between community groups and health practitioners is needed (Nutbeam 1999). The emphasis by Nutbeam on widening the potential for coalitions of interest on health

literacy with an enhanced focus on both interactive and critical forms of health literacy, alongside an urgent focus on functional literacy, is evident in his recent work:

> *"Some widening of content and methods will need to occur. Improving health literacy in a population involves more than a transmission of health information, although that remains a fundamental task. Helping people to develop confidence to act on that knowledge and the ability to work with and support others will best be achieved through more personal forms of communication, and through community based outreach.....and efforts to ensure that the content of health communications not only focuses on personal health, but also on social determinants of health"(Nutbeam 2008: 2077).*

Irish family health literacy course

In 2005 NALA developed and piloted a family health literacy course which aimed to empower people to engage with the health service in the community and in a clinical setting. The skills that it aimed to develop included problem solving, communications, decision making and interpersonal skills. This course is integrated into family literacy courses and used in a number of community settings.

Implications for Irish Public Policy

It is interesting to note that though health literacy is not core-funded in Ireland and still has to be mainstreamed in public policy, most of the pertinent issues regarding health literacy are dotted across the Irish public policy landscape. Many of the evidence-based proposals discussed above are either explicitly or implicitly part of current Irish health policy.

As noted above, the principle of 'patient centred care' must be adopted in order to fulfil information sharing, the promotion of understanding and empowering strategies between medics and patients, which in turn enhances health literacy and health outcomes. It is now ten years since the Irish government published its Health Strategy, entitled: Quality and Fairness, a Health System for you. One of the four national policy goals identified in this report was 'National Goal no.3: Responsive and Appropriate Care Delivery'. Patient centred care was listed as the number one objective:

> "**Objective 1: The patient is at the centre in the delivery of care:**
>
> One of the guiding principles of the Strategy is that of a people-centred health system. A responsive system must develop ways to engage with individuals and the wider community receiving services. This quotation commits the government to greater sharing of information between patient and medic which is achieved through improved communication. It also commits the government to allowing patients in community settings take more control over their own care, in the way Nutbeam (2008) and others have argued for.

New Structures - Primary Care in Ireland

The Irish governments Primary Care Strategy (2001) set up a clear model which prioritised the case of Primary Care Health Teams. This was developed further in the Health Services Executive, Health Transformation Programme (2007-2010). According to the HSE National Service Plan (2010), already almost 400 of these are up and running. The HSE has gone further and moved towards 'integrated care' based at the level of the community .This is based on a population health approach which emphasizes health promotion and the integration of health and social care, with the patient at the centre and where health and social care professionals share information between themselves and with the patient. It is clear that these developments provide the ideal model and health services infrastructure for the enhancement of communication between medical personnel and patients, moving towards enhanced health literacy and health outcomes. These initiatives, all moving in the direction of improving health literacy and public health outcomes are even more necessary in the context of the ageing Irish population. There will be 1.2 million people over the age of 65 in Ireland in 2030 (CSO 2006). Improved health literacy can promote greater self management of

care. "While Irish people are living longer, they are developing more chronic conditions, which call for a greater degree of self-management"(CSO 2006 in NALA 2009: 4). As people age, there is a greater likelihood of ill health.

Primary Care and Health Literacy

For Inez Bailey, there is a consensus that primary care offers a huge opportunity for health literacy. However, she believes that the exact nexus to develop health literacy as embedded in primary care has yet to be worked-out by policy makers and stakeholders. NALA's work on health literacy to have any chance of success must develop 'specific messages to the different clinicians in the different areas'.

For Ciara O'Rourke, the expansion of primary care and its integration with community care offers significant potential for health literacy 'without a shadow of a doubt'.

Gerardine Doyle sees the links between primary care centres and community centres as providing an ideal opportunity for health literacy training for health professionals in the future.

Sarah O'Brien sees the development of primary care as offering strong potential in the area of health literacy. This may well provide greater opportunities for health literacy service providers, working in areas such as Literacy awareness and Audit for Healthcare Settings. The growth of primary care also offers the potential for programmes that address both service user & service provider.

The rolling out of health literacy audits in health care settings and programmes of education for health professionals within accredited programmes such as in the USA and in the area of continuous professional development is vital. More emphasis on Irish research in the area and a greater policy output is vital. In the Irish context:

> *" ...Health literacy has yet to be fully recognised and researched as a health issue. As an issue, it is only discussed in the realm of health promotion and needs to be tackled from a number of perspectives such as research, communications, policy, healthcare and accreditation"(NALA 2007: 6).*

Health Literacy & Irish Public Health Policy

Sarah O'Brien, Health Promotion Unit, HSE

Sarah O'Brien points to the SLÁN report (2002), which evidenced almost one fifth of people felt that access to better information would improve health. She believes that the HSE (2008) Health Status of the Population report is also useful in the area of health literacy: it shows that people in lower socio-economic groups tend to experience more illness, poorer quality of life and premature death. However, she makes it clear that the report does not demonstrate the links between these poor health outcomes and health literacy.

Looking to the future, she says that the Department of Health is developing a Public Health Policy (2012-2020), which provides an opportunity for health literacy to be incorporated. This policy document will guide public health policy and action across the health system. She believes that the World Health Organisation's (WHO) Healthy Cities project is expected to be a central component of the Department of Health report, adding that the WHO European Network of Healthy Cities have identified health literacy as a priority issue.

Internationally, Sarah O'Brien points to significant policy developments in the area of health literacy: In the UK, there exists the inclusion of health literacy in Life Skills/Lifelong learning frameworks which is developing stronger links with the Dept. of Education & Skills. In terms of research however, apart from the EU Health Literacy Survey, much published research appears to focus on tools to assess literacy levels of patients. In contrast, the points to the dearth of research available on effective health literacy interventions.

She sees Canada as a leader on all aspects of health literacy. Her view is that Canada appears to have taken a strong population health approach to health literacy which addresses policy, research & practice. In turn, the population health approach adopted by the HSE here in Ireland, which is quickly tracking through into the Public Health Policy from 2012 – 2020, is informed by the Canadian population health approach.

Important steps in this direction continued to be made in Irish public policy. The Department of Health in dealing with the structural determinants of poor health in its National Health Promotion Strategy clearly identified that poor literacy leads to the individual possessing less information about her health, which is the essence of poor health literacy:

> *"Poor literacy skills are a barrier to many opportunities in our information-based society and this also limits access to health information and health services"(Dept of Health 2000: 20).*

The SLÁN (2002), which reported on the health and lifestyle of the Irish population through the use of survey data, asked a specific question on health literacy in regard to the quality of health information that they enjoy. The results speak clearly to the need to improve the quality of health information provided to the general public:

> *"In addition, the results of the SLAN (2002) survey showed that 17.9% of those interviewed found health information difficult to access and understand. Of those interviewed, 60% believed that better access to health information would help them improve their health"(HSE 2011:2).*

The challenge now is to educate the health and social care personnel on the benefits of health literacy and to use community education as a tool to promote health literacy which now co-exists in the same place as community health delivery. Such moves would deliver on the health literacy increases in the way that has been described already as best practice by experts on health literacy, such as Rudd (2010); Nutbeam (2008), Schwartzgerg (2009) and others.

Immigration to Ireland since the early 1990s has created a multi-cultural and multi-ethnic society. This has greatly enriched Irish culture. However, for many whose first language is not English, there are difficulties involved in reading and understanding health information, either through the use of the written word or in direct communication with health professionals. As a result, the Health Services Executive in 2007 published its National Intercultural Health Strategy. This runs from 2007-2012 and commits the health services to enhancing:

> *"Information, Language and Communication: Provision of accessible information to service users, together with availability of interpretation and translation services, were highlighted as key priorities requiring urgent attention"(HSE 2007:10).*

Again, there is no scarcity of clear commitments from the Irish state to delivering policy goals that would improve health literacy. In this context, the commitment to improving communication mechanisms to empower service users from other countries is strongly consistent with the approach advocated in the US by the Joint Commission (2007), the US Department of Health and Human Services (2009) and independent research experts such as Mancuso (2011), as cited above.

In recent years also, public policy in the area of health literacy has been aided by the setting up of a Master's degree in health literacy in UCD. Building on Nutbeam's (2008) view that health literacy can be viewed either as a risk factor from the point of view of the patient or as a personal asset, UCD health literacy researchers James Fulham and Gerardine Doyle have noted the fact that there is still a high level of unawareness among health professionals of the fact that half the population has low literacy skills:

> *"Evidence from a recent Irish survey found that only 31% of GPs are aware that half of the Irish population have low literacy skills" (2009 MSD Irish GP Omnibus Survey).*

The need for an urgent public policy mainstreaming of health literacy in Ireland is even more pronounced, when we consider the results of the NALA/MSD Health Literacy Survey (2007):

- 20% of Irish people aren't confident in dealing with health care professionals
- 50% would only ask a healthcare professional to explain something to them that they didn't understand
- 20% didn't understand fully the instructions on medical packaging
- 67% had difficulty understanding hospital signage
- 60% didn't understand the word 'prognosis'
- 10% admitted to taking the wrong medication as they didn't correctly understand the dosage.

Health Literacy in Ireland: Challenges & Opportunities

Ciara O'Rourke believes that the Department of Health needs to expand its resource allocation to health literacy. She is of the view that the HSE's performance in training only 300 staff in health literacy out of 100,000 needs to be dramatically improved: 'anybody working with patients should be trained in health literacy'. Her view is that 'the government and the HSE needs to have a policy about health literacy'. In addition, 'as part of their induction, everybody who starts work in the HSE should be trained in health literacy'. The health literacy audit by NALA should be rolled out in all hospitals and its is the hospital managers who need to take the lead in this area. However, specific interventions which work at 'a patient level' in the area of health literacy are also needed. ▶

- Gerardine Doyle strongly commends the work of MSD and NALA in the area of health literacy. She is enthused about the value added in Ireland for health literacy, arising from the research and PhD student(s) in UCD. She added that UCD is applying for EU round seven funding in a transnational way with the University of Louvain and others. However, she points to the very small amount of national funding for health literacy. She also points out that there is no specific government policy in the area of health literacy.

  She does not believe that any of the published Irish health policy documents offer any significant statement on health literacy. Her view is that there is 'nothing really in these documents on health literacy'. However, Ireland is involved in the health literacy survey. She is positive about the fact that a national advisory group has been set up to produce a policy blueprint in this area which will go to the government. She believes that Ireland is beginning to take its place internationally amongst countries where there is a strong interest to develop health literacy. She believes that the situation in Ireland has improved a lot in the past five years with the MSD awards; the UCD research and the work of NALA

  For Sarah O'Brien, the health literacy agenda hasn't progressed significantly for several years in Ireland. There appears to be little integration between Departments on the issue of literacy & health literacy.

  She believes that in recent years, the HSE has made efforts to take a strategic approach to health literacy across the organisation. Health literacy has been incorporated into the HSE Health Inequalities Framework & action plan, with training provided to Communications staff. However, she is of the view there is not a strong national research agenda for health literacy, nor is she aware of dedicated funding for health literacy initiatives. Her belief is that public awareness of health literacy is not very high.

  For Inez Bailey NALA does not have the resources to make health literacy a bigger part of its wider work at this time. It is possible however for NALA to design learning programmes for individuals who would like to learn more on an illness they are suffering from and how it should be managed. Inez emphasises that the NALA approach is to put the individual at the centre and build the required programmes around her. She also stresses the need to promote health literacy as an area in its own right, which differs from the current overall 'basic literacy service' that exists.

The Future for Irish Policy

NALA continues to be the main advocate for adult literacy in Ireland. NALA has been involved in dealing with adult literacy problems over three decades. As such, it deals with a root cause of health literacy which is literacy itself. This work continues to be vital, as it increases the capacity of the human resource base of the population going forward also.

With the support of the Health Promotion section of the Dept. of Health, NALA has developed health literacy outputs which have a dual focus of bringing health literacy education to a greater public audience with the outputs also acting as catalysts towards the development of mainstreaming health literacy in public policy. These outputs include:

- Health research
- Literacy friendly teaching packs
- Family literacy model: developed and evaluated
- Literacy audit for healthcare settings and
- A health literacy awareness DVD (NALA 2009: 4).

Nonetheless, health literacy has yet to make the same breakthrough in the area of public policy. Consequently, NALA (2007) has identified key areas of action to improve this deficit:

- Develop stronger linkages with HIQA so that health literacy can penetrate quality standards
- Work more closely with the Health Promotion Hospital Network.
- Introduce health literacy to the Dept. of Social Protection as part of the National Anti-Poverty Strategy (NAPS).
- Develop a working relationship with medical and nursing schools to get health literacy on to curricula.
- Work with other national health care institutions such as the Institute of Public Health.

NALA/MSD Health Literacy Initiative

An existing beacon in driving the health literacy policy agenda have been the NALA/MSD Health Literacy Initiative incorporating the Crystal Clear health literacy awards. These awards in recent years have been gaining in their reach and popularity and have been increasing public awareness of health literacy. Hundreds of community

based projects have entered and dozens of awards have been made to reward health literacy innovation. Examples from within the 2010 award winners include:

- The Fatima Health Project – A community-led health literacy project in Dublin
- DEBRA Ireland – A self-help organisation representing people with a rare skin condition

HIQA: New Irish Health Literacy Partnership Possibilities

Inez Bailey does not think that HIQA will offer a very strong response to the publication of the new European Health Literacy Survey (2010). HIQA has such a large amount of work at the moment, that they don't have the resources to get involved in health literacy. Inez is certain that the health literacy will ultimately also have to be based on national standards which will be immensely helpful. However, she believes that this will take some time yet.

The view of MSD's Ciara O'Rourke is equally sceptical on HIQA taking on the role of incorporating health literacy in to its national standards on health and social care. She believes that health literacy should be clearly part of HIQA's work but believes that HIQA itself does not see health literacy as part of it's role: 'they see themselves a level removed from that, and see themselves as partnering with hospitals at a higher corporate level'.

For Gerardine Doyle, HIQA has a huge role in the health literacy area. It is in charge of patient safety and patient risk. There is a member of HIQA on the national advisory panel for health literacy.

Sarah O'Brien believes that HIQA may take such a narrow view of health literacy that it will mitigate success in the area: 'the potential may be limited to establishing standards – such standards may be limited to a narrow understanding of health literacy: provision of accessible information, literacy proofing written materials, use of audits.

The clear message to be drawn from these awards is that local communities and communities of interest are developing strategies to improve and promote health literacy amongst their members. It is obvious that health literacy education at the level of the individual can best be achieved through community-based measures, as recommended by Nutbeam (2005). The research discussed above indicates that health care organisations and professional bodies also need to be targeted. NALA (2009: 7) has stated:

> *"With a health literacy policy statement, the Department of Health needs to encourage professional organisations to develop a position on health literacy and issue policy statements and papers. They could also provide a training framework for administrative and medical practitioners".*

Specific Health Literacy Budget

NALA (2009) also argues for a specific health literacy budget. This report also points to the need to ensure that health literacy questions are inserted in to all population health surveys going forward. It also suggests that national health screening programmes such as Breastcheck could develop synergies with local VEC literacy programmes in order to develop health literacy education. It also advises that healthcare settings should be encouraged to use NALA's Health Literacy Audit resource pack and that healthcare settings ensure that spoken instructions to patients should be provided in 'a clear understandable language'(NALA 2009: 6) to people from different nationalities and ethnic origins, in line with the National Intercultural Health Strategy (2008) of the HSE. It also recommends that all national health initiatives be proofed for plain English.

It is timely to suggest a clear set of public policy proposals to blueprint the rolling out of health literacy education in all the relevant health literacy domains. The results of the 2010 Health Literacy Survey (Austria, Bulgaria, Germany, Greece, Ireland, The Netherlands, Portugal and Spain) will be published in late November 2011. As part of the task from an Irish perspective, a national health literacy network and a national advisory panel have been set up. Perhaps, the use of the results through the work of the panel will be one element in driving the project towards its ultimate public policy goals.

Health Literacy in Ireland: Future Priorities

Inez Bailey believes that the linking to health literacy to national standards in health should be the number one priority for the future. This should be connected in to a dedicated government policy in the area of health literacy and which is 'inter-agency in its scope'. There should be some large organisation taken on as the 'driver' of health literacy at a national level.

Ciara O'Rourke's future priorities for health literacy are firstly, the development of a national 'health literacy programme, similar to the road safety programme… that is what's needed for this'. This should ensure that patients are aware that 'they have a right to say to their doctor, doctor I don't understand that, can you explain that to me again'? Secondly, the HSE needs to do 'a nationwide campaign, maybe in partnership with NALA, on encouraging people to be more responsible about their health by asking the right questions, understanding what their health care professional is saying to them.. ...this will then encourage the health care professionals to speak in plainer English'. She would also prioritise training for primary care providers to improve their communication skills and to train them to speak in plainer English.

Sarah O'Brien's four future priorities for health literacy are:

A. Develop a comprehensive national health literacy policy

B. Engage with WHO Healthy Cities National Network

C. Research to establish health outcomes of improved health literacy

D. Evidence based effective health literacy interventions

She adds that: 'Health literacy needs to be seen as much broader than written and oral communication on health and referral to VEC Adult Literacy Programmes'.

Conclusion

This paper has benchmarked the current state of the art of health literacy in Ireland. It has done so by examining the published evidence for Ireland and through assessing four key players on the development of health literacy in Ireland. The development of health literacy in Ireland has been set in the context for its development internationally. The international development of best practice internationally has been outlined. The Irish performance in the area of health literacy, mainly through the work of NALA, set against it to make a comparison. The paper has examined the public policy context for health literacy in Ireland also. It has identified the key stakeholders and pointed to opportunities for further development in the area. It has also identified blockages.

The paper has found that health literacy in Ireland is not as developed as countries such as Canada or the USA, but has being doing very well in the past five years with very limited resources. Ireland could claim to be mid-range in any internationally league table on health literacy development, if one existed. It is clear that health literacy in Ireland is not well represented in public policy. However, the rolling out of exciting developments in health policy such as enhanced primary care and integrated care provide obvious opportunities for the development of health literacy. The evidence provided in this paper from expert reports internationally and interviews establish without doubt that improved health literacy leads to improved health outcomes. These benefits are urgently needed in Ireland. The economic cost savings benefits to the health services and the health benefits to the individual provide a win-win scenario arising from improved health literacy.

It is clear that community-based education is the most advantageous model for the future development of health literacy. The existing model covering literacy education through the partnership of the VEC and NALA can also be developed to roll out health literacy education, once policy and resources are committed to it. It is clear that health literacy should also be expanded to go beyond the Plain English and Communication focus of NALA. These are clearly the most immediate areas and given the very modest budget for health literacy, these have been the priorities. Nonetheless, in addition to these priorities, health literacy has a far bigger job of work to do in the area of health promotion. There are clear benefits to providing a statutory responsibility on hospital managers to audit their health care settings for health literacy. It is also clear that health literacy should be inserted into the curriculum of education and training courses and primary degree courses for doctors, nurses and all health and social care professions. This is particularly the case for general practitioners and hospital doctors.

However, the first step in developing these interventions is in public health policy. The results of the European Health Literacy Survey (2010) are to be published at the end of November 2011. A separate set of results specifically for Ireland will follow almost immediately. A national advisory committee has been set up to work with the Irish

government on these findings. There is an urgent need for the Irish government to commit to a full stakeholder engagement with the view to developing a comprehensive published public health policy on health literacy. This document would need to provide an organisational and funding framework for health literacy over period of years. Synergies also need to be explored with the HIQA in regard to building health literacy in to national standards for health and social care.

The current reconfiguration of health services is one of the most significant developments in many years in Ireland. These developments put people and communities at the centre of health care policy. There is an enhanced focus on quality standards, multi-disciplinary team working and tailoring health care provision with the patient/client at the centre. This is predicated on the continuous professional development of staff and the use of an evidenced-based approach the training of health care staff and to the serious health and social care challenges that face the Irish population. It is obvious that health literacy should be a key ingredient in these developments and they provide the ideal springboard for injecting a decisive impetus in to mainstreaming health literacy in Ireland. It is hoped that public policy rises to this challenge.

Recommendations

I. The immediate commitment by the Irish government to providing a comprehensive policy document on health literacy.

II. The use of the existing community-based literacy structure to roll out health literacy education and the provision of the necessary resources to do so.

III. That, managers of health care settings be statutorily responsible for the health literacy audit of their health care settings.

IV. That, exploratory talks should begin between HIQA and NALA to explore the development of health literacy into national standards for health care delivery.

V. That health literacy should be formulated as learning outcomes in degree courses and continuous professional development training for all health care professionals with the immediate priority being hospital doctors and general practitioners.

VI. That health literacy should have an expanded remit in the area of health promotion.

Appendix 1

Health Literacy Developments in Ireland

1997 Publication of Irish results of OECD International Adult Literacy Survey.

1999 National Health and lifestyle survey SLAN, Department of Health

2000 National Health Promotion Strategy 2000- 2005 Department of Health

2001 Health Literacy Policy and Strategy Report, NALA

National Anti Poverty Strategy Submission 2001

2003 NALA's Plain English Service launched, funded by Department of Social and Family Affairs.

2004 Development of first family health literacy course, NALA

Health Promotion Strategy reviewed

2007 NALA/MSD Health Literacy Initiative launched – Crystal Clear healthcare award and Omnibus Health literacy Survey.

NALA Position Paper on Health Literacy

2008 National Intercultural Health Strategy 2007 – 2012 HSE

Launch of UCD Health Literacy Phd Programme.

2009 Literacy Audit for Healthcare Settings, NALA/HSE

2011 Irish results of European HL survey published

Appendix 2

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