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Editorial

Health literacy: new packaging for health education or radical movement?

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Jane Wills is Professor of Health Promotion at London South Bank University. Her main areas of interest have been the developing discourse of health promotion and its professionalisation. Common themes underlying research in the Institute of Primary Care and Public Health are a concern with issues of appropriateness, accessibility and equity, and with the development of methods for user and community participation in the shaping of health policy and priorities.

Has anything excited the field of health promotion in recent years so much as health literacy? At the IUHPE conference on health promotion and health education in Vancouver in 2007 there were more than ten papers concerning health literacy and theme groups that separately focused on the development of the concept and what it means for practice and policy. Perhaps a reason for this enthusiasm is that the concept of health literacy harks back to the Ottawa Charter's view of the purpose of health promotion as enabling people to have greater control over their health; a much broader goal than that more usually adopted by governments of encouraging people to adopt healthy behaviours and avoid unhealthy ones.

Yet there are at least two reasons why we should hesitate to join what is emerging as an international movement about health literacy. Firstly, the relevance of health literacy for health practice has been largely confined to a concern that those with low levels of functional literacy will be unable to understand health communications – a necessary step to patient compliance.[1] Secondly, although the complexity of the concept has been widely acknowledged[2–5] there is no consensus on its meaning or measurement and health promotion again risks whole-heartedly embracing an evocative but imprecise concept just as it has done with 'community' or 'empowerment'. Indeed, in a persuasive and scathing critique, Tones has argued that health literacy IS nothing but the concept of empowerment re-badged.[6]

That estimates of health literacy exist -nearly half of all American adults – 90 million people are deemed lacking in health literacy – suggests that health literacy can be measured in a valid, reliable and comparable way. This is far from the case. In the USA, where the concept of health literacy has been embraced most readily, it is understood as the capacity to "obtain, process, and understand basic health information and services needed to make appropriate health decisions.[7]" The decisions alluded to include making an appointment or reading a medicine label thereby associating health literacy with functional literacy. The main response has thus been to develop tools for diagnostic testing in clinical settings and strategies for assessing readability and suitability of printed materials and for evaluating individual reading skills of adults as well as educational interventions to increase literacy skills. Yet the WHO Commission on the Social Determinants of Health widens the scope of the concept to include understanding the social determinants of health.[8]

Should we care about health literacy? There is some evidence that low health literacy is linked to poor health outcomes.[7–9] The premise appears to be that low literacy means health communication is not understood, hence poor self management and perceptions of health responsibility and worse health care utilisation. Health literacy is also cast as a social determinant of health (as is functional literacy) both for individuals and populations due to its impact on socio-economic status, employment and ability to access services. Not having access to, or the ability to understand, health information is undeniably disempowering. But whether health literacy exists as a social determinant independent of educational attainment and income has to be questioned. The watchword of the CSDH is the need to understand the "causes of the causes" and the points along the chain of social production of health/illness where it is desirable (and feasible) to intervene: through broad redistributive policies that aim to alter fundamental social inequalities; or through less ambitious, intermediate policies that seek to empower members of socially disadvantaged groups such as tackling their health literacy.

Whilst attempts to tease out the concept of health literacy have resulted in wider definitions they all encompass the ability to find, understand, evaluate and select information from different sources and then put this to use in decision making in that specific context. In neoliberal political environments where individuals are expected to take responsibility for their

health there is a greater expectation that people will be able to navigate an increasingly health consumerist society.[10,11] *This may be expressed differently – a clinical concern to produce 'good patients' who comply with health messages and access services appropriately; a political concern to produce active citizens able to navigate health information, products, services and systems; or an educational concern to encourage informed decision making. The Freirean notion of literacy was that it would be a tool for social change and political action and Abel describes health literacy in a similar vein as increasing the chances of changing health-relevant living conditions.*[12] *Freire's pedagogy involved a questioning based on the vocabulary of learners' daily lives which would promote a dialogue between participants which would address the questions of their social condition.*[13] *'Critical health literacy' is thus both a skill involving a critical understanding of health determinants and self-efficacy (the confidence/capacity to act) and an outcome, an asset to be developed as a consequence of health promotion. Being able to read a food label is one thing, understanding why a Macdonalds is so cheap, filling and ubiquitous is another.*

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