Editorials

Health literacy and the 'inverse information law'

Low literacy frequently leads to disadvantaged socioeconomic circumstances, and adverse effects on health that are independent of other risks. More directly, individuals and populations with lower literacy are less likely to be responsive to established approaches to health education, less likely to use disease prevention services, and less likely to be successful in the self-management of long-term conditions.[1] A recent King's Fund study exploring the impact of health promotion campaigns in England showed little effect on health behaviours among people with few or no qualifications.[2]

These findings have generated considerable international interest in the relationship between literacy and health. This interest is observable in research into the measurement of health-related literacy, examination of the relationship between low literacy and a range of health conditions, and testing of interventions designed to mitigate the effects of low literacy.[1,3,4]

Much of this growing body of research has emanated from the US, where the term 'health literacy' is commonly used to describe the set of individual literacy capacities that act as a mediating factor in health and clinical decision making.[5] Poor literacy skills are viewed as a risk to be managed in clinical care. Doctors have a key role in managing this risk; a study published in the *BJGP* shows that, for older patients with low health literacy, those with a better relationship with their doctor feel they have a higher level of involvement in their care.[6] The accumulating evidence is resulting in the development of interventions to ameliorate the effects of low literacy on patient knowledge and outcomes[4,7] and in recognition of the need to reduce health system barriers to care.

In other parts of the world, including England, the term health literacy has been used differently. Drawing from the broader study of literacy, the term 'health literacy' is used to represent a more positive set of cognitive and social skills that can be actively developed through general health education, and more targeted patient education.[8] Such educational interventions can support greater autonomy and personal engagement in decision making, in the same way that general literacy and numeracy can be improved through education, and lead to greater personal autonomy and control.

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The development of these skills is not only dependent upon cognitive ability but also exposure to different forms of communication and message content. In turn, both clearly depend upon levels of literacy, numeracy, and language competence in individuals and populations. Individuals with underdeveloped skills in reading, oral communication, and numeracy will not only have less exposure to traditional health education, but also less developed skills to act upon the information received. For these reasons, strategies to promote health literacy will remain inextricably tied to more general strategies to promote literacy, numeracy, and language skills in populations.

Levels of general literacy and numeracy in the English population are low[9] and new data released in December indicate that as many as 61% of England's working-age population have low health literacy (G Rowlands, unpublished data, 2012; available from author). Furthermore, those with the lowest levels of health literacy have the least access to health information; the 'inverse information law'. Information about health, particularly that relating to clinical conditions and choices for treatment, is inherently complex. It is likely that there is a mismatch between the existing literacy skills of the population, and the health literacy required to understand and use health information to become and stay healthy and manage illness. This presents a significant challenge to general practice, and to the wider NHS.

Current government policy places a premium on greater engagement and involvement of patients in decisions about their personal health, and in shaping local health services; 'no decision about me without me'.[10] Such a level of engagement assumes a level of access to health information, and understanding and confidence to use it, that is well beyond many individuals in the population. There is a real risk that the commendable objectives of current policy will founder on the practical challenges posed by low levels of literacy, and poor health literacy, in the population. Without active intervention, it is likely that, as with many other initiatives in primary care and public health,[2] those with higher levels of education and health literacy will benefit most, and those already disadvantaged will be left further behind.

In the US, recognition of the impact of low health literacy has resulted in a range of initiatives in clinical practice to develop services that are more accessible and useful for people regardless of their health literacy skills. Approaches include improved physician communication using techniques such as 'teach-back' to ensure that patients have fully understood advice and instruction,[11] improved patient education materials and decision-aids to be more useful for individuals with low literacy and numeracy,[4] and improving the health care environment to make it more accessible to some who typically find it intimidating and alienating.[12]

A similar approach in England could have a significant impact on the quality of care and communication with many of the most vulnerable patients. GPs not only have

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an important role in ensuring access to understandable information for people with low literacy and numeracy skills, but also in supporting patients to play an active and knowledgeable role in decisions about their health.[6] The specific forms of intervention referred to above are producing results for US patients, ensuring that many of the most vulnerable and needy are actively engaged in well-informed decisions about their health and health care. Rapid and systematic transfer of these communication techniques, and modifications to patient education materials and clinic processes to England are required to make the attractive rhetoric of 'no decision about me without me' a meaningful option for a majority of patients.

Most GPs have neither the skills nor the time to actively develop patient health literacy skills; teaching adults with low basic skills is highly specialised. GPs are, however, based within the communities they serve and are ideally placed to develop strong and effective links with adult educators. With imagination and a commitment to interdisciplinary working, GPs and adult educators could form exciting and effective partnerships to build health literacy skills in patients and communities and thus ensure that the opportunities brought to patients through shared decision making and shaping local services are open to all. Initiatives to develop health literacy skills in disadvantaged groups through community and workplace learning have shown learner enthusiasm for learning about healthy lifestyles, using the NHS, and communicating with health professionals, and have demonstrated an increase in learner knowledge and an increase in healthy lifestyle choices.[13]

Health literacy is emerging as an area of importance in the NHS. Low literacy and numeracy skills are likely to be a significant contributing factor to ill health. Supporting patients to develop health literacy skills could bring real benefits to patients and the NHS. General practice is ideally placed to both improve communication and effective interventions for patients with low literacy and numeracy skills, and to provide a vital community link to education specialists to support patients to develop new skills for health.

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