

Editorial: Moving Health Literacy from the Individual to the Community

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Medicine and public health are often described by their differences; the former focuses on individual patients, whereas the latter addresses health issues of populations, which are often related to non-medical determinants of health. Health literacy, strictly speaking, is a non-medical issue that is often viewed as a problem of individuals. We seek to identify those with low health literacy so we can eventually apply different interventions in the clinical setting, or provide a better explanation of treatment in the hope of making care more effective. Because individuals with low health literacy can be difficult to identify in clinical practice, some have argued that we should respond to the health literacy problem with universal precautions. This would comprise using teachback methods, easily readable printed material, and simplified instructions for health tasks, such as medication regimens with all patients. There is support in the finding that even individuals who are fully health literate prefer easy-to-read material.¹ Such universal strategies bring us closer to a population approach to health literacy.

Although we are supportive of the universal precautions approach, we argue that it is time to think beyond addressing health literacy in the clinical setting. Numerous studies have shown that the health of individuals is affected not only by their own socioeconomic status but

also by the characteristics of those who live in their neighborhoods.² Thus, we might want to view health literacy as a neighborhood or community issue, as it is strongly related to both income and education. How might we consider health literacy as a community issue, and what are the implications for action?

Estimates of other community characteristics are routinely used to guide interventions: the rates of diabetes are used to implement community-based education and other public health responses, and rates of crime are used to allocate law-enforcement resources. In this manner, we ought to be able to estimate the level of health literacy in a neighborhood, thereby having tools to tailor community approaches to address the problem. Given the wealth of data available in the recent National Assessment of Adult Literacy (NAAL),³ we propose building predictive models of health literacy by linking sociodemographic characteristics to health literacy scores in the NAAL. Such predictive models could then be used to estimate the health literacy levels of communities all across America. In fact, census data will not only support such estimates on a census tract basis, but will also provide a profile of the racial/ethnic and economic characteristics of residents. Recent work in mapping racial/ethnic disparities in quality of care (Allen Fremont, MD, PhD, May 14, 2007),⁴ as well as the Public Health Disparities Geocoding Project,⁵ have demonstrated the power of maps to make such tract-level data readily accessible to the public and to policy makers. Imagine the power that such a map detailing the health literacy status of a community could have.

What might we do with such information and who would benefit? For starters, it would enable us to operationalize a basic principle of population health—to

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efficiently allocate resources and interventions commensurate with the greatest need. It would be particularly important for providers and health plans serving these communities to focus their implementation of universal precautions. In fact, they could probably skip any attempts to screen for health literacy in their patient panels. Pharmacies located in such communities could receive additional support to implement interventions aimed at supporting medication adherence. Vendors of over-the-counter and prescription medications could ensure adequate labels for drug safety and use appropriate language labels based on characteristics of the community. Community health worker programs that stress clear health communication and ensure understanding of health issues could be developed, and such programs would stand a greater chance of success because of their relevance to target populations. Medicaid programs, private health insurers, and other entities serving these communities might find that supporting such programs is a cost-efficient use of resources. The idea of measuring community health literacy is an idea at least worth testing.

Schools in communities could also play an important role, not only by providing access to literacy classes, but by equipping students to serve as an intergenerational resource to parents and grandparents. Similarly, other community and faith-based organizations serving such communities could know clearly that health literacy should be an area of focused programming. Market segmentation in advertising and media is already well developed; media outlets in such communities could also play an important role by providing appropriate, action-oriented educational programming and messages.

In the long run, the goal is for communities themselves to become health literate, thereby supporting all residents directly or indirectly, to be able to access, understand, and act on information about their health. In addition, health literate communities would be empowered to interact both with the local health care

system and local governments to ensure access to resources, ranging from parks to clinics, that can improve health. Although only a hypothesis, it seems plausible that if the health of individuals is influenced by the people they live with, increasing the health literacy capacity of a community can serve to improve its health more broadly.

The 2003 NAAL is the first national literacy assessment containing measures of health literacy, and its results will be used to provide a baseline for the Healthy People 2010 health literacy objective. We are hopeful that collaborations between researchers at the National Center for Education Statistics will not only allow us to build a much needed health literacy map of America, but also further the development of interventions for communities whose health literacy needs are better defined by such a tool. Such a resource can then guide efforts by policy makers, industry, workers, schools, and community organizations across the country as they work within neighborhoods to improve health. Given the magnitude of the problems of health literacy, it is time to embark on targeted and meaningful paths to improvement. Let us hope we find willing partners to join hands to advance this public health goal that is important to us all. ■

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