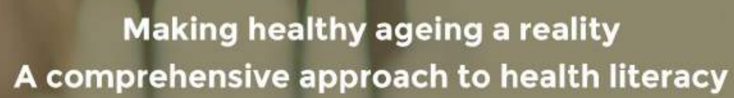

Making healthy ageing a reality
A comprehensive approach to health literacy

IROHLA Consortium
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www.healthliteracycentre.eu

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Further reading on the activities in the IROHLA project:
www.irohla.eu

Further reading on health literacy research in the IROHLA project:
www.healthliteracycentre.eu

The research leading to these results was done within the framework of the IROHLA project co-ordinated by the University Medical Center Groningen, and has received funding from the European Community (FP7 2007-2013) under grant agreement no 305831.

A bird's eye view over the IROHLA project

When the IROHLA (Intervention Research on Health Literacy of the Ageing Population in Europe) project was approved by the European Commission, I was asked: "Can you manage a project with 20 partners in 10 countries? Will you be able to get along with universities, health organisations, health insurers, European consumer organisations and small businesses?"
After three years of hard work, we can say: "Yes, we have managed!" We have been able to work together, learn a lot from each other, inspire each other and ask critical questions about our intentions and objectives. Our aim was to go beyond the ivory tower of research, and to work in a way where many stakeholders feel at home, through co-creation and out-of-the-box thinking and working.
Now that we have almost reached the end of the project, we are happy to present a series of products to inform and inspire others. We have produced:

1 Numerous scientific publications.

2 A website www.irohla.eu with activities, best practices and actual news on health literacy.

3 Two policy briefs. One is for national level policy makers, explaining how healthcare would benefit from inclusion of health literacy in health programmes. The second one is for practitioners and brings together evidence from health literacy research to inspire people to take action.

4 A web portal (www.healthliteracycentre.eu) that gathers and summarises all of the information we have collected, reviewed and validated in an easily accessible way.

5 And finally, with the help of our work package leader responsible for communication and dissemination, EuroHealthNet, we have produced this brochure.

The brochure describes some of the work done by partners, and how it can benefit older people in Europe. It covers different elements of the work that has been undertaken, showing the enthusiasm and commitment of those involved. Above all, it shows dedication to the common goal of healthy ageing for vulnerable groups in society.
In this project high-level goals and ideals have to be translated in to feasible actions to make a difference. And there, dear reader, is where you come in: it is our sincere hope that our efforts will be taken up by you, to inform the next stage of policy and practice.

Jaap Koot MD MBA
IROHLA Project Coordinator
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Improving health literacy: why we need a comprehensive approach

Jaap Koot, Jeanet Landsman, Andrea de Winter, Department of Health Sciences, University Medical Center Groningen

In this article we describe how IROHLA developed a comprehensive approach to improve health literacy in the older population. First, we conducted an extensive literature review, which revealed four principles underlying health literacy. We then examined good practices to identify promising areas for interventions. Like in public health, we found that successful interventions try to impact the whole range of people in the healthcare chain (patients, families, doctors, etc.) using a variety of activities.

1 Health literacy is crucial for healthy ageing. Health literacy is a multifaceted concept and can be defined as the degree to which an individual has the capacity to obtain, communicate, process and understand basic health-related information and services to make appropriate health decisions. This can further be split into functional health literacy (related to the reading, writing and understanding health information), interactive health literacy (the communication of health-related information and knowledge), and critical health literacy (the ability to critically analyse information and use it to take greater control over life events and situations). In the past, research focused mostly on functional health literacy. More recently, the focus has shifted to interactive and critical health literacy. Connected to this, health literacy is increasingly considered an asset for staying healthy or regaining health after illness. In IROHLA we mainly focused on health literacy as an asset for older people and carried out research into control over life events, which we termed empowerment and self-management.

2 Behaviour is critical for achieving results in health literacy. Focusing on decision making or critical health literacy means concentrating on the behaviour of people, in addition to understanding and communicating. Changing or encouraging the maintenance of people's behaviour requires the competencies, knowledge, skills and attitudes of both older adults and health professionals.
In IROHLA we drew upon knowledge from health promotion and applied the outcomes of behavioural science research. Based on this, we developed a taxonomy or classification of different intervention objectives, which shows the steps necessary to achieve improved health literacy, both at the individual and organisational levels.

3 The dynamic balance of health literacy. Health literacy is not like traditional literacy, in terms of how well someone can read or write. Instead, health literacy is about the discrepancy between someone's skills and competencies in relation to the demands placed upon them by the health system. It is especially important for older people, who have to cope with more chronic health problems than younger people, and face more physical, mental and social challenges due to ageing. In fact, the competencies of many older people to manage their health often fall short compared to their needs.

4 The outcomes of health literacy interventions are a result of interactions between people. Functional and interactive health literacy concentrate on the individual and his or her ability to do something. However, critical health literacy concerns interaction between the individual (with a certain level of health literacy) and other people, for instance family, friends, neighbours, caregivers, health professionals, and even health managers and insurers. People live in a social context that influences their behaviour and determines the outcomes of change processes. Therefore in IROHLA we looked carefully at interactive aspects of health literacy interventions.

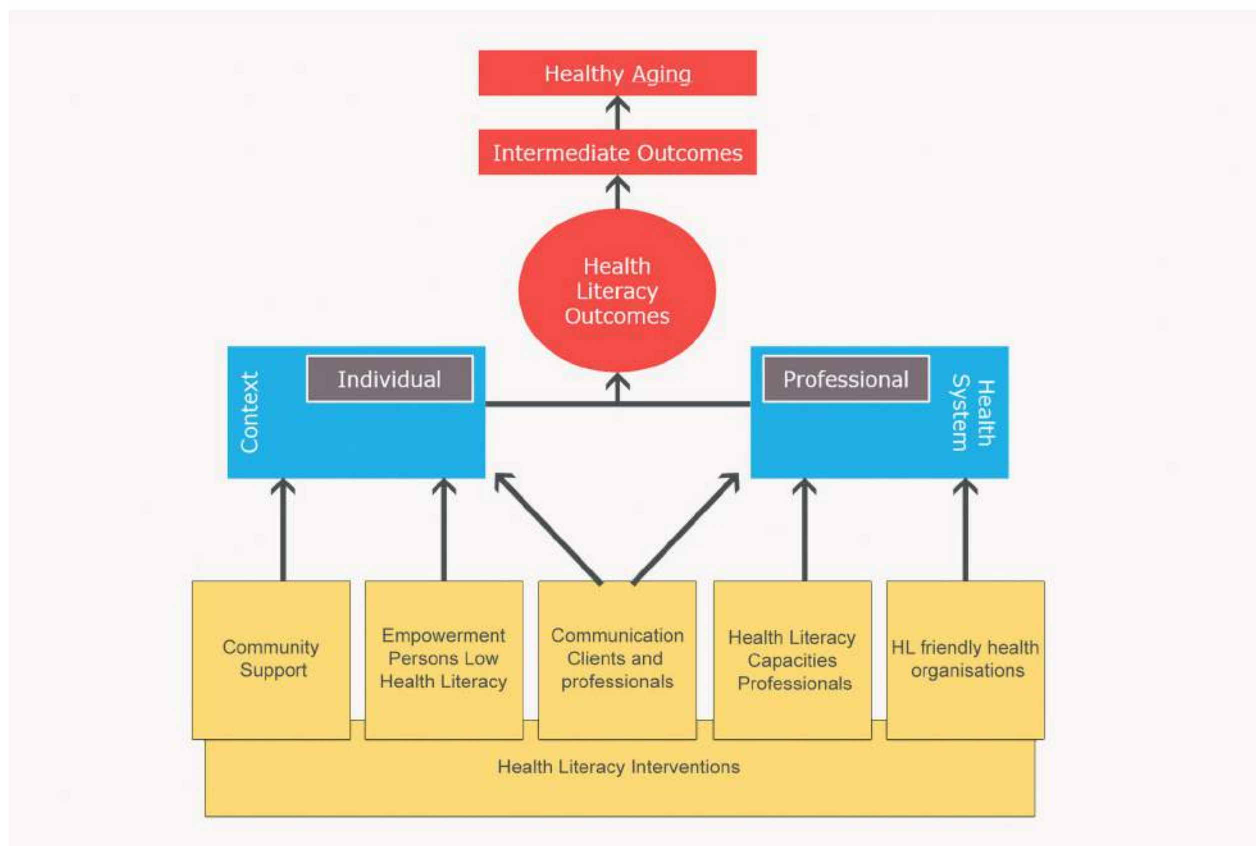
In our research we found that successful interventions target different groups at the same time, for example, patients and professionals, patients and their relatives, or professionals and their colleagues in health facilities. We also found that successful interventions often combine different activities, like providing health information with follow-up messages and encouraging skills development with measures to increase motivation to change behaviour and reduce barriers to achieving change.

The need for a comprehensive approach by tackling multiple targets and using multiple activities is similar to the approach in public health. For instance, when it comes to reducing obesity, successful interventions tend to include activities on healthy nutrition and physical activities, involve peers and their families, while at the same time taxing unhealthy products.

IROHLA shows that better health literacy outcomes can be achieved when interventions take place in four areas:

- Empowerment of older people with low health literacy
- Strengthening social support systems, including those connected with the family, caregivers, and communities
- Improving the communication and interaction skills of health workers
- Adapting the health system to improve access for all groups in society

When these activities take place simultaneously and when they reinforce each other the effects are stronger than when they address issues in isolation: the comprehensive approach is more effective. Different stakeholders have called for effective strategies to improve health literacy problems.
We hope that our guidelines for policy and practice, which describe the comprehensive approach in more detail, will contribute to healthy ageing of older adults and the reduction of socioeconomic health differences in society.



Preventing human tragedies and reducing healthcare costs: The promise of health literacy-friendly healthcare environments

Jane Sixsmith, Lecturer Health Promotion, School of Health Sciences National University of Ireland Galway, Andrea de Winter, Assistant Professor, Scientific Coordinator IROHLA Project, University Medical Centre Groningen, Johanna Reiman, Executive Director, Baltic Region Healthy Cities Association.

People with low levels of health literacy have poorer health outcomes, and there are two main reasons for this. The first is that people with lower levels of health literacy are less likely to take part in health-promoting activities and disease prevention programmes. The second is that those with low health literacy and suffering from chronic illness are less able to manage their conditions themselves, for example by following a medication regime properly.

This leads to hospitalisation, ill health and even premature death. Not only is this a human tragedy, but it also massively increases financial costs on health systems.

Interventions that aim to improve levels of health literacy have tended to focus on individual skills, and there are many different methods for assessing and strengthening people's health literacy abilities. This stands in sharp contrast to the lack of measures developed to assess health professionals' knowledge and skills in engaging with patients with limited skills.

Recently, attempts have been made to shift the focus from individual skills and abilities to those of health professionals and the environment in which they work, such as hospitals. Hospitals supply information that people are expected to be able to understand and make use of. This information includes appointment letters, signage in the hospital, and information about treatment and care. Often, medical staff have unrealistic expectations of patients' abilities, and this can be compounded if information is not readily accessible to patients or is overly complex, particularly for those with low health literacy.

Interventions have also been designed to assess whether healthcare settings promote health literacy, for instance by focusing on whether they enable patients to actively manage their own health. Developing health literacy-friendly environments has the potential to improve people's quality of life, people's experience of the healthcare system, and patient safety. Many of the tools developed to assess and reduce environmental barriers to health literacy come from North America, and the approach is increasingly used in Europe too. Health literacy environmental interventions are made up of multiple actions, such as assessment of navigation, interpersonal communication, design of printed, audio-visual and digital materials, and action planning and evaluation for optimal health service delivery.

In the IROHLA project we evaluated the use of three country-specific health literacy environmental interventions in hospitals in Ireland, the Netherlands and Finland. A wide range of aspects of the environment were assessed including navigation and written patient information. Ease of navigation around the physical hospital environments was assessed through the use of walking tours with service users with high and low health literacy. Written materials were assessed for use of plain language and presentation with service users and best practice assessment tools. Hospital staff were interviewed and asked about their perceptions of the use of the environmental health literacy interventions. We found that the interventions identified barriers and facilitators to health literacy capacity development in hospitals, and concluded that relatively modest changes could have real potential to improve patients' experiences and the quality of healthcare.

“John has got diabetes – but he has to eat like the rest of us”: The importance of improving critical health literacy

Louise Meijering, Assistant Professor in Methodology of Socio-Spatial Research, University of Groningen

Co-authors: Christine Fenenga, Research Fellow, University of Groningen; Cinzia Giammarchi, Project Officer/Researcher, Regione Marche; Liesbeth de Wit, PhD Researcher, University of Groningen

Why is critical health literacy important?

We all make choices that affect health in our everyday lives. These choices are based on our knowledge, which in turn is based on information and advice we get from family, friends, health professionals, the internet and elsewhere. It is important that people, and older adults in particular, are able to interpret, judge, sift and use health information provided in the context of their daily lives. This ability is called critical health literacy. Having a sufficient level of critical health literacy enables older adults to make informed health decisions and act on them. Our research on critical health literacy gives a voice to the older adults whose health is at stake, and whose voice often remains silent.

Key elements of critical health literacy

When looking at older adults' health knowledge we usually find they have a general awareness about health. For instance, they are aware of risk factors for diabetes, or symptoms of mental health problems. Older adults also typically know what they would like to learn more about. Peer-learning is a fruitful strategy to increase older adults' knowledge about health. Co-learning involves different people, such as older adults, health professionals, family members, and policy makers, listening to each other's perspectives, and contributing to find mutual understanding. An underlying assumption is that people can learn from each other, no matter who they are. In this process, the knowledge and views of different people need to be acknowledged: for instance, most health professionals would find group sessions on diabetes awareness useful, whereas some older adults might not see their value.

Older adults face different barriers and opportunities to act upon health-related knowledge. Barriers include language, stress, social isolation, financial situation, physical distance to healthcare services, stigma associated with specific health conditions, and a lack of understanding among health professionals about the cultural background of the older adult. Opportunities, on the other hand, include cultural openness and scheduling enough time for appointments with health professionals so that questions can be asked. So, even if John knows he has diabetes, and knows he should adapt his diet accordingly, various barriers in his everyday life can prevent him from changing his behavior. For instance, he may not be able to afford the food that he needs, or his family members might not have the time to take his 'special' diet into account.

Context: an essential ingredient to critical health literacy

Why do we have to understand 'health' in the context of everyday lives when taking a critical health literacy perspective? Because 'being healthy' can mean different things to different people. For example, health can be seen as something holistic and achieved through a particular way of living. Or it can be seen as something that can be controlled through the use of medicines or natural remedies. It really depends on the cultural context that we grow up and live in.

How can we improve CHL?

A successful approach to improving health literacy is the Community Based Participatory Approach (CBPA). There are eight project phases to CPBA, which together facilitate improvement of CHL:

1. careful assessment of the current situation
2. identifying a shared problem
3. making a plan together with all the stakeholders
4. identifying and designing project activities
5. carrying out project activities
6. analysing the findings and identifying good practices
7. disseminating the findings
8. evaluating and monitoring throughout the project. A key characteristic of community based participatory approach is that all stakeholders are involved in every phase of the project. This approach links well with critical health literacy, because critical health literacy also focuses on engaging different stakeholders, the importance of context, and on taking action. Thus, through community based participatory approach, the critical health literacy of communities can be improved.

Why a multi-stakeholder approach is essential to promoting health literacy – a view from Finland

Interview with Karolina Mackiewicz, Development Manager Projects & Communications and Johanna Reiman, Executive Director; Baltic Region Health Cities Association

Please tell us about your background and how this led up to IROHLA.

JR: The Baltic Region Healthy Cities Association (BRHCA) was established in 1998 and has been involved in various projects connected to health literacy and ageing. Health literacy is now one of our core areas of work. In that sense the IROHLA project fit very well into what our association has done and is doing!

How can health literacy contribute to the Healthy Cities programme initiated by the WHO?

JR: One of the members of Baltic Region Healthy Cities Association, the city of Turku in Finland, joined the WHO Healthy Cities network as a collaborating centre. This links the BRHCA to the WHO's work. Our main target group is city decision makers: encouraging them to take account of health when they are discussing and implementing new policies. However, it doesn't only apply to the social and welfare sectors, but also to education, city planning, and so on.

KM: The key objective of Healthy Cities is to work on tackling health inequalities, in particular – socio-economic inequalities in health. This, in turn, is directly connected to demands to increase health literacy. These things are very much dependant, that's why improving health literacy is such an important matter for Healthy Cities.

Can a partnership between different organisations and stakeholders benefit the health of people in cities and regions?

JR: Partnerships have been a core part of the Healthy Cities movement from the start. They have brought together municipalities, companies, universities, associations, because all of them possess knowledge and expertise necessary to improve health. Commitment to work across sectors is crucial in health promotion and health literacy, because it ensures that the organisations involved have the time, resources and understanding of what needs to be done to improve things.

Did you face any challenges working on IROHLA?

KM: Well, we are practitioners, while IROHLA is a research project. Bringing these two worlds together was a challenge, but at the same time it provided us with a lot of valuable knowledge. We think it was beneficial for other partners to apply their ideas practically and to make the language simple enough so the people outside of the academic world can benefit from IROHLA.

Can you give an example of an improvement in a community or city that was influenced by IROHLA?

JR: We collaborated with many different stakeholders within IROHLA, for example with the National Institute of Health and Welfare in Finland, and the Finnish Ministry of Social Affairs, and we were able to articulate the importance of health literacy. Finland is quite advanced in the area of health promotion, but health literacy is only a small part of it. We were able to draw their attention to the issue, which hadn't really been addressed properly before. There are currently several policies concerning health promotion, but health literacy is barely visible in this, so we were trying to change that.

What do you think will be IROHLA's long-term legacy in the Baltic Sea Region?

KM: I believe that efforts to improve health literacy will be eagerly taken forward by our partners from the Baltic Sea Region. For instance, during the conference of the Nordic Health Literacy Network I presented the IROHLA project and all of the participants were really excited about it. They are waiting for the final results, especially connected to health literacy environmental assessment tools. When I was speaking about this topic, they realised that not much is currently done about it. Even though IROHLA focuses on older people, it also improves more general understanding of health literacy. I was speaking with someone who works with children and they said the IROHLA policy brief is really useful for their work too.

JR: We work with several countries surrounding Baltic Sea Region and I think they can all benefit from IROHLA in one way or another. Moreover, Finnish society is the fastest ageing society in the EU, so the fact that IROHLA is focusing on older people is particularly beneficial for us. I'm certain that IROHLA will bring us many useful developments.

How health literacy can contribute to the efforts to improve healthy diet

Stephanie Howard Wilsher, Research Associate in Public Health; University of East Anglia

Co-authors: Julii Brainard, Senior Research Associate; Charlotte Salter, Senior Lecturer Health & Communication; Yoon Loke, Professor of Medicine & Pharmacology; Norwich Medical School, University of East Anglia

Much of the research on health literacy focuses narrowly on how to understand basic health information, such as instructions on prescribed medicines. The thinking being that armed with knowledge, people will act on the information to improve their health. However, in reality this rarely happens – neither among people with chronic conditions who rely on medicines to sustain their quality of life, nor among the general public for whom an unhealthy diet or other lifestyle choices can have serious health consequences.

An estimated 2.7 million deaths around the world are due to poor diet and low fruit and vegetable consumption. An unhealthy diet containing lots of fat and sugar (energy-dense foods) is linked to health conditions, such as obesity, diabetes and many other chronic problems. There are many reasons why people consume an unhealthy diet. It could, for instance, be due to poor health literacy skills, such as misjudging portion size, difficulty accessing nutritional information, or trouble understanding nutritional labels. Food labels and nutrition or dietary facts are often presented in technical rather than 'plain English', and this makes it difficult for people to understand dietary information.

Poor health literacy skills could be related to poor literacy. Twenty per cent of the population can read at a level no better than the average ten year old. This could partly explain why many health promotion campaigns are often not understood, let alone change behaviour. For example, the 'five-a-day campaign' in the UK, which encourages people to eat at least five portions of fruit and vegetables each day, has had little effect on changing dietary behaviour: average fruit and vegetable consumption remains at three portions daily, as in much of the Western world.

Consuming a healthy diet relies on many individual and environmental factors. Individual factors include taste and preference to eat healthy foods rather than energy-dense convenience foods. Additionally, self-efficacy skills, such as being able to buy, prepare and cook fresh foods, are consistent predictors of fruit and vegetable consumption. Other factors include the cost and availability of different foods and social support in the form of encouragement from family members to eat fruit and vegetables. Some people feel they don't have time or can't be bothered to buy and prepare fruit and vegetables to make meals from scratch, so resort to using convenience foods. In fact, this issue of time and effort is often linked to poor cooking skills. The responsibility for cooking a meal usually rests with the female partner in a family, who often works and whose ability to cook greatly influences family nutrition. However, the preferences of the husband or partner and children are also influential.

A conceptual framework based on the theory of planned behaviour and risk theory was used for research on young British men, aged 18-24 in urban London and rural Norfolk, to explore fruit and vegetable consumption. This age group is renowned for having a low level of fruit and vegetable consumption. Of the 34 young men interviewed, only one had heard of the five-a-day campaign and all were confused by what counts as a portion. None knew about the link between fruit and vegetable consumption and health benefits. In fact, the group was generally unaware of public health efforts to promote healthy eating at all. When they were shown dietary messages from health organisations they found them ambiguous and irrelevant to their lives. When the young men were divided into relatively high (4+ portions daily) and low (<3 portions daily) consumers, other factors also impacted on fruit and vegetable consumption: high consumers had high self-efficacy, wanted to be healthy in the future, and their families positively influenced their diet. Low consumers on the other hand had low self-efficacy, relied on convenience foods, and were also influenced by their social lives and friends to "live for today".

Health promotion has only recently considered health literacy an important factor in research on behaviour. But the simple notion that imparting 'knowledge' enables people to improve health is, however, clearly wrong. Not only is this knowledge not imparted to many, there is actually convincing evidence to show that changing dietary behaviour requires more than just having information or knowledge: it requires understanding the circumstances and viewpoints and skills of the people concerned. Theoretical models, such as the theory of planned behaviour, are useful for explaining behaviour and developing successful interventions because they provide a framework that can be tried and tested. Likewise, health literacy research should consider the many factors that influence medication adherence and use theoretical models, based on the experiences of patients, to develop successful interventions.

Health literacy and health promotion – a view from Germany

Interview with Dr Heidrun M. Thaiss, Executive Director of the Federal Centre for Health Education

Why is the concept of health literacy important in health promotion?

At the international level, the concept of health literacy is receiving growing attention. In Germany, health literacy is also becoming increasingly important in healthcare, health promotion and disease prevention. As health literacy is an essential asset to staying healthy - and for recovering swiftly when ill - it should also be an important goal for health education.

Why wasn't health literacy recognised earlier on as an important factor in health promotion?

Health literacy is based on established concepts of health promotion, like empowerment, participation and shared decision making. Health literacy as a distinct concept, in relation to health education, first appeared in the literature in the 1970s. It gained importance in the mid-1990s and has since been a popular concept in research and health policy over 20 years. It became evident that health literacy is of key importance for health promotion as it strengthens individuals' capacities to access and use information in order to make appropriate health decisions and improve and maintain health.

What health promoting projects or campaigns has the German Federal Centre for Health Education (BzgA) been involved in?

Preventive healthcare and health preservation are two of our priority goals. Our work contributes to reducing the incidence of new cases of disease through education (primary prevention), to improving the early detection of disease (secondary prevention), and generally to strengthening health-related potentials (health promotion). To this end, we educate and influence attitudes and behaviours, enabling people to behave more healthily, recognise and avoid risks, and assume responsibility for their own health and that of others.

How can quality be assured in health literacy and health promotion?

High quality health promotion can only be assured on a permanent basis by sharing good practices and co-operating with many different stakeholders. We should aim to provide needs-based prevention services, and to ensure appropriate utilisation of disease prevention services. This requires preparation of tools and recommendations, as well as the development of curricula for use in basic and specialist vocational training, as well as non-vocational continuing education. BzGA develops and tests strategies to open up these tasks to new organisations and to disseminate findings more widely. Some of these strategies focus on using new media. The aim is to solve problems more efficiently. Conferences are useful for communicating the results of our work, experiences and recommendations relating to quality assurance, thereby providing important stimuli for more effectiveness and efficiency in the field of health promotion and health education.

How does IROHLA contribute to knowledge of health literacy in the older population?

Promotion of health literacy for elderly people is particularly important when we consider the current demographic situation. Health literacy is especially relevant for the older population, as they often have more health problems than younger people, and face physical, mental and social challenges due to ageing.

IROHLA has taken a comprehensive approach, which targets multiple groups, i.e. individuals and their social environment, in addition to professionals and the health system. The essence of the comprehensive approach is that different activities are mutually reinforcing, so that interventions strengthen each other. Such a comprehensive approach can help tackle the problems associated with limited health literacy abilities in the older population. We think that the IROHLA guidelines based on this comprehensive approach should be very useful and relevant for policy and practice.

Why research on health literacy in Europe is important

Interview with Prof. Sanna Salanterä, PhD, RN, Professor of Clinical Nursing Science, University of Turku

Could you tell us about your research interests? How did they lead you to work on health literacy in the IROHLA project?

Our work at the University of Turku focuses on different ways of promoting patient education and empowerment. We realised that some of our educational materials did not actually meet patients' needs. As a result, we started to change our approach in Turku University Hospital. We started working with the concept of health literacy, mostly with children. We developed an annual teaching programme for nurses, to educate them about how to communicate better with patients, focusing in particular on issues related to patient empowerment. We got involved in IROHLA through the Baltic Regional Healthy Cities Association. It enabled us to start looking at health literacy from an older person's perspective.

What aspects of health literacy interest you?

We are interested in how to measure health literacy, how to assess it from different perspectives, how to improve the knowledge of patients and how to educate patients. We want to evaluate the outcomes of these educational efforts. This is especially important for nurses, as they are the ones who usually have to deal with gaps in patients' knowledge and health literacy. They are also in daily contact with patients, so are well situated to develop patient education programmes.
Therefore, we started developing different tools to help with that.

Why is health literacy research among older adults important?

Older people often have many health problems at the same time, so learning about health conditions is more challenging for them. A person might have rheumatoid arthritis and heart problems, so he or she needs to understand how to cope with these two problems simultaneously. Furthermore, elderly patients often experience deteriorating memory, which is an issue that we always have to take into account. Nowadays, when more and more people have dementia or Alzheimer's, we need to understand their way of thinking, so that we can support them in their daily lives.

Is there anything more you would like to add?

I would like to add that IROHLA has been an excellent project and the issues it has addressed are exactly those we needed to focus on. In Turku University Hospital we started a patient evaluation group, which means that a group of voluntary patients is telling us how the hospital should function from their perspective. Part of it also focuses on health literacy and empowerment, things that have been explored in IROHLA. In that sense, the project and its ideas will live on in our hospital well after it has ended.

AGE-Platform Europe: Health literacy key issue to ensure access to quality healthcare for older people

Interview with Anne Sophie Parent, Secretary General at AGE Platform Europe

Why is AGE-Platform interested in health literacy?

That Europe's population is ageing rapidly is old news. This demographic shift brings social and economic challenges, not least for healthcare systems. The older we get, the greater the risk of disease and disability. But old age is not a disease itself. Although many of us who live longer do have different health conditions, we are also showing an encouraging ability and willingness to manage them ourselves. We live longer, but unfortunately on average we live too many years in poor health at the end of our lives. Improving health literacy to empower our ageing population to age in better health is therefore a key issue for us.

Can you explain what you mean by empowerment of older people?

Empowering older people to live longer in good health requires work on a wide range of policy areas that have an impact on older and retired people. It is not enough to ensure access to quality health and long-term care. Building health literacy among senior people combined with more effective patient-centred disease prevention and health promotion strategies, including shared decision making, self-care and better adherence to treatment, is indispensable to achieving longer and healthier lives. It's never too late to take action to improve one's health. Helping individuals to make better decisions about their own health and well-being will contribute to a more efficient use of our limited resources.

How do you see active and healthy ageing?

Given the increase in the number of senior people, it is important to emphasise that older people wish to continue to contribute and participate actively in their communities and in democratic processes, and to draw attention to the economic and social value that they bring. This is not to detract from the attention to ensuring that older people who need care and support are provided it, nor is it to deny that there are costs associated with an ageing population. However, older people should not be considered a homogenous group because of their age, but rather be considered in terms of their capacity to develop and contribute to society. Older people are integrated in society in many ways. They are part of social networks of friends and family, are active in clubs and associations, provide care to relatives, work as volunteers and are economically active. However, older people are often vulnerable to social exclusion. Potential obstacles to equal social participation of older people include poverty, poor health, lower levels of education, lack of transportation, difficulties accessing services and age discrimination.

Has IROHLA brought you new ideas?

In this context, improving health literacy can pose various issues. It is true that health literacy may be a greater challenge for older people, who have to cope with more health problems than younger people, and face more physical, mental and social challenges due to ageing. But health literacy is an issue that affects us all and everyone has a role to play in addressing it. Relatives, neighbours and friends, as well as healthcare workers and other professionals, can all work together to strengthen people's health literacy capacities. The promising health literacy interventions and the policy recommendations developed in the IROHLA project have provided us with valuable evidence-based information that will help us in our advocacy work to create an age-friendly Europe.

The international success of photo stories in increasing the effectiveness of patient-doctor communication

Interview with Ruth Koops van 't Jagt, PhD student Comprehensible Language in Health Related Documents, University of Groningen

How did you come to the idea to start working with photo stories?

One of the findings of the IROHLA project was that narrative forms of health communication can improve health literacy. I wanted to do something with this finding and together with Ype Driessen we decided to develop a series of photo stories. The aim is to make users aware of possible barriers in doctor-patient communication, to portray recognisable and real-life step-by-step scenarios and role models that help form behavioural intentions and communication strategies and that decrease shame in older people and increase older patients' communication abilities.

The photo stories help patients and doctors because they raise awareness about difficulties related to communications. They offer realistic and recognisable scenarios and role models and portray solutions and strategies to overcome those issues.

You got already positive responses when developing the photo stories, we understand?

Responses to the photo stories have been really enthusiastic, and there is a lot of interest to use them. One participant stated: 'These (photo stories) are much more effective than straightforward advice. They are clearer and more recognisable'. Another participant agreed:

A traditional brochure is much more detached. The message is just bluntly communicated. If this is the case, then do that. If you do not dare, you won't become any wiser. The photo stories really clearly present the steps. If you don't dare, the story helps you with the different steps

I have already received requests from GP practices, a geriatric specialist, a social health care organisation in Amsterdam, Health Care Projects for disadvantaged groups in North Netherlands, and – to my surprise – a high-school language teacher to use the photo stories.

In fact, photo stories are already used in Latin America, North America, South Africa and Mediterranean countries to communication health information. However, these photo stories are usually longer than our photo stories. To our knowledge, we are one of the first to use short, one-page photo stories as a health communication tool in the Netherlands and Europe.

What are your ambitions with these photo stories?

In the future we would love to study the effectiveness and potential applications of photo stories and focus on their applicability in other contexts (e.g. self-management for diabetes, psycho-social care for adolescents), in other cultures and in other media formats. We would also love to explore whether photo stories as a health literacy intervention tool can be incorporated into training and education of professionals and whether they actually influence real conversational behaviour.

Ruth Koops van 't Jagt is supported in her research by John Hoeks, Professor in Communication and Carel Jansen, Professor in Communication and Information Studies, University of Groningen; Andrea de Winter, Assistant Professor and Menno Reijneveld, Professor of Community and Occupational Medicine, University Medical Center Groningen

Why improving health literacy for older people could benefit the economy in Greece

Interview with Pania Karnaki, Co-Director of Research – Head of European Projects, the Institute of Preventive Medicine, Environmental and Occupational Health, Prolepsis

How has IROHLA added to your work at Prolepsis?

Health literacy for senior citizens is something that we have been involved in for quite some time. IROHLA has enabled us to explore the ICT world and see how it could support us in promoting public health. It was important, as it provided the opportunity to develop a new ICT application, pilot test it to see how useful it was to the target group, and consider how it could be built upon in the future.

How can e-health applications improve health and health literacy?

The advantage of e-health applications is that you can tackle a huge range of medical issues with it. You can also address disease prevention and self-management, which are crucial for Europe given its ageing population. Use of such applications improves health literacy and enables people to take control of their health and manage health issues. This, in turn, leads to better health.

What was the aim of the pilot application?

It focused on nutrition and physical activity and was based on the delivery of personalised messages and self-monitoring of progress. We wanted to raise awareness about these topics using ICT health applications. One of the main objectives was to make older people more familiar with ICT and to encourage them to manage their health issues themselves. The experience of IROHLA was very positive because we had the opportunity and the funds to design something right from the start and pilot it with the socio-economic group we felt needed it most. I think EU research projects and the structural funds are a very good ways to reach groups that are most in need.

Were there barriers to implementing the pilot project?

The barriers that we experienced in our pilot project were mostly related to the lack of infrastructure and knowledge. For example, many people don't have access to the internet or even to a computer. We also faced numerous internet access problems, so we always needed to have an IT specialist with us. We also needed to motivate people, because learning something new can be disheartening. It was important for us to highlight how easy the application was to use. The other barrier was that people are not willing to pay for an ICT service. They expect it to be free, so if we had to charge money, the application wouldn't be used.

What is the potential of e-health applications in health promotion and healthcare system in Greece?

We feel that there is a lot of potential for e-health applications in Greece. Unfortunately, this potential is not being reached right now, especially for lower socio-economic groups. The population in Europe is ageing rapidly and this puts pressure on social and welfare systems. E-health applications could facilitate the work both of medical professionals and health systems. We would like to see the potential exploited more in Greece.

How do you see e-health applications developing in the short term?

It's a very difficult time for Greece right now, but using ICT and e-health applications could contribute to solving the problems caused by the crisis, like staff shortages and wages being cut. In addition, less focus is being placed on prevention and health promotion activities. ICT applications hold a lot of potential to overcome these problems and contribute positively to improving and promoting health, especially among disadvantaged populations. There is a lot of interest and belief in e-health, even among older people – something we didn't anticipate. However, I think that the human aspect and interaction will always be necessary. I see e-health complimenting and contributing to professionals' work.

Are e-health applications equally accessible to all social groups? If not, what are the challenges to be faced and how could they be tackled?

Equity should be a main objective with these kinds of projects, but the reality is that in Greece people with higher socio-economic status are more familiar with ICT. Statistics show that use of the internet in the country is not as widespread as it could be. Through the pilot we realised that participants from lower socio-economic groups face more difficulties concerning internet connection or ownership of a PC or tablet than higher socio-economic groups.

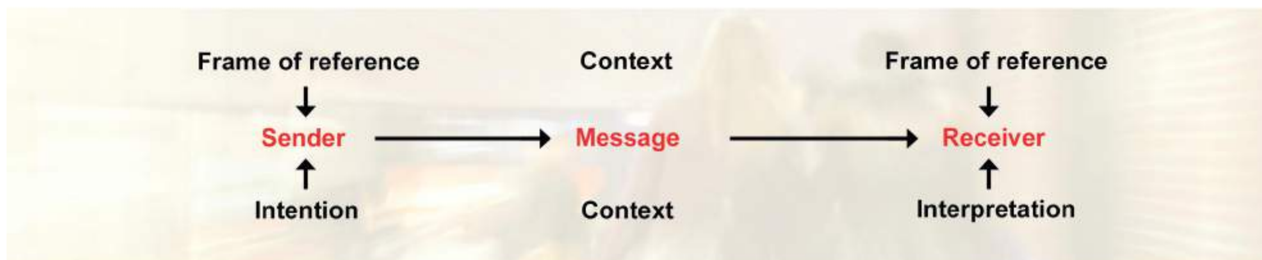
An evaluation of health literacy communication skills in the education curriculum of professional healthcare workers.

Herman Veenker, PhD & Wolter Paans, PhD, Hanze University of Applied Sciences, Groningen

The Research Group in Nursing Diagnostics at the Hanze University of Applied Sciences produced health literacy educational materials for healthcare professionals and nurses as part of the IROHLA project. As preparation, we performed a literature review that focused on interactions between individuals (clients or patients) and health professionals.

We found that most curricula for medical students and other health professionals focus on skills concerned with providing adequate information to patients, using the 'Sender-Message-Receiver' model. Curricula rarely are focusing on competencies to support patient empowerment and their autonomy.

We enriched the Sender-Message-Receiver model (in red below) – by adding personal and contextual factors (in black) – so that it incorporated health literacy aspects. We concluded that the sender and receiver should be much more aware of personal and contextual factors in order to communicate effectively. In simple terms: communication is not just about words and syntax, but about how, when, why and by whom the words are used.



In the review of the literature we four promising practices that can help to train health workers to communicate in such a way as to improve health literacy. These four practices take personal and contextual factors into account:

1. The Four Habits model, which describes the essential behaviour of a clinician during consultation stages.
2. The Teach Back model, which describes methods of verification of understanding by the patient.
3. The Communication Skills Development System, which describes systematic learning of communication skills through self-assessment and feedback.
4. The Ottawa Decision Support Framework, which describes a systematic approach towards decision making by patients, and methods for shared decision making.

Later on in IROHLA, the concepts developed through the literature review were incorporated in a training programme for health care professionals. The website **www.healthliteracycentre.eu** provides information about this training.

Improving health equity and health literacy: shared goals?

Paulina Nakielny, Linden Farrer, European Centre for Innovation, Research and Implementation for Health and Well-being (CIRI), EuroHealthNet

There is a strong association between levels of health literacy on the one hand and socio-economic status, level of education and cultural background on the other hand. We know that people with these backgrounds also suffer from worse health outcomes, but do efforts to improve health literacy reduce health inequalities, or vice versa? A new report produced by the UCL Institute of Health Equity suggests that by improving one, we can also improve the other.

This report, *"Local action on health inequalities, improving health literacy to reduce health inequalities",* suggests that there are three main strategies to improve health literacy and reduce health inequalities. The first is to address people's abilities to manage their health and chronic conditions. The second is to improve healthcare and social systems' responsiveness and clarity to ensure that people can receive help when they need it and navigate through the system easily. The third involves addressing the social determinants of health, which contribute to health inequalities.

An example in the report of the first strategy is Healthy Eating for Young Children, which aims to encourage healthy nutrition during the early years of life by involving parents and children in practical activities and group discussions. It is targeted at families living in the poorest areas of the UK, and had the effect of encouraging parents to make positive behavioural changes, such as checking food labels, serving appropriate portion sizes and making economical choices when shopping for food.

The second strategy revolves around clear communications and instructions in healthcare settings: essential if people are to understand and act on health-related information.
Ensuring that health-related instructions are concise and written in plain language really can contribute to better health outcomes. Some studies have shown that using pictures instead of text improves understanding of information, especially for people with low levels of health literacy. Examples include listing the potential side-effects of a medicine in a table rather than in text, or explaining the required dosage verbally. Because the onus is not only on patients but also on those treating them, healthcare workers need to be trained to communicate health information clearly.

The third strategy is to directly address the social determinants of health. An example is Skilled for Health, a government-funded course which aims to reduce health inequalities by improving literacy and numeracy skills combined with health improvement topics. The programme is aimed at adults living in disadvantaged communities in England. As a result of the course over half the participants reported eating more healthily and exercising more. Moreover, their literacy, language and numeracy skills increased and 80% of the participants intended to take up further education courses.

In addition, innovative approaches to improve health literacy, such as e-health and m-health, should not be forgotten. M-Health is an emerging part of e-health, where ICT improves health products, services and processes. Mobile health applications can be used to improve health literacy among people and encourage healthy lifestyle and nutrition, though it should be kept in mind that many older people do not have the technical knowledge or means to use such technologies.

In conclusion, all three strategies for improving health literacy are important. The first two strategies help people to manage their health and create more responsive health and social care systems. The third suggests that action to reduce social inequalities can also simultaneously improve people's level of health literacy. In some ways, the two are so intertwined that one intervention can improve health literacy and health equity at the same time.

The conclusion of this report fits perfectly with the research findings of the IROHLA project that identified empowerment of individuals and communities as a priority, together with capacity development of professionals and changing paradigms in health care organisations.
In the IROHLA project it is labelled as a comprehensive approach.
The UCL report also emphasises the concept of critical health literacy: there is much more than reading and understanding health information; there is also the ability to take informed decisions and to be in power of your own health.

Health Literacy Centre Europe: Where health literacy for healthy ageing begins

Dr Jeanet Landsman, coordinator Health Literacy Centre Europe, Dr Andrea de Winter, Assistant Professor, Jaap Koot MD MBA, coordinator of the IROHLA project, Department of Health Sciences, University Medical Center Groningen

One of the aims of IROHLA is to share findings and recommendations with a larger audience to inform policy and practice. We wanted to make the project's research available in a format that is accessible and useful to different stakeholders involved. After consultation with IROHLA partners and other experts we concluded that an interactive website would be the best possible means of dissemination. A website is easy accessible, can be updated regularly and can incorporate new knowledge. Supported by the IROHLA funding from the European Commission, we developed and launched a portal called Health Literacy Centre Europe (HLCE).

The portal is there for policymakers at national, regional or local level, for practitioners and for researchers. All groups can find their own specific information in the portal.

Health Literacy Centre Europe provides articles, practical tools and insights from the IROHLA project. It also connects to other initiatives around the world showing guidelines and best practices for health literacy. The portal is a living and interactive place of exchange and interaction. It will grow in the coming years with new partners and new topics such as promoting health literacy among children and families.

The portal is easily accessible as it has different navigation tools, following the interests of the visitors: policy makers can find a complete overview of what is happening in strategic developments in European countries, while practitioners can find concrete information on interventions and tips and tricks on how to develop activities. Researchers can find state of the art information and links to scientific publications and ongoing research projects.

Some topics you can find on **www.healthliteracycentre.eu**

The portal gives access to training materials for professionals in different European contexts. Also, photo novellas are shown to help patients communicate with their doctor. There is an extensive section on e-health and m-health and lessons learned for development of app. There are checklists to assess barriers and facilitators for access to health care. The portal contains tips and tricks for development of interventions, for example how to take context of activities into account.

We are happy that all participants of the IROHLA project contributed to the website. We hope the HLCE will become the 'first port of call' when you need information on health literacy. We adopted the 'Wikipedia model', which implies that people can edit and add new knowledge on health literacy interventions. We also want to expand to other areas like health literacy for young people and health literacy on the workplace.The website offers space for comments and interactions; offers opportunities for uploading and sharing knowledge. It is our sincere wish that it could develop into a vibrant meeting point for health literacy in Europe. Be our partner at **www.healthliteracycentre.eu.**

Members of the IROHLA consortium:

	Name Institution	Country
1	University Medical Center Groningen (UMCG)	The Netherlands
2	CBO – TNO organisation	The Netherlands
3	University of Groningen (RUG)	The Netherlands
4	Jacobs University, Bremen	Germany
5	Baltic Region Healthy Cities Association	Finland
6	National University of Ireland, Galway	Ireland
7	Norwich Medical School, Faculty of Medicine & Health Sciences	England
8	National Institute for Health Development (OEFI)	Hungary
9	EuroHealthNet	Belgium
10	Institute of Preventive Medicine, Environmental & Occupational Health (Prolepsis)	Greece
11	Italian National Institute on Aging (INRCA)	Italy
12	Federal Centre for Health Education (BZgA)	Germany
13	AGE – Platform Europe	Belgium
14	European Social Insurance Platform (ESIP)	Belgium
15	Regional Agency for Health Marche Region	Italy
16	Hanze University of Applied Sciences Groningen	The Netherlands
17	Cambo Industries Digital	Greece
18	Live Online Coaching	Germany
19.	IP-Health Vitalinq	The Netherlands
20.	Educational TV-NL (ETV)	The Netherlands
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