Measuring Organizational Health Literacy

Why measure organizational health literacy in parallel to the population measurement by $HLS_{24/25}$?

General adult population surveys like the most recently conducted European Health Literacy Population Survey 2019-2021 (HLS_{19}), but also HLS-EU and earlier studies, demonstrated the relevance of general health literacy (HL) and of specific HLs: considerable proportions of adult residents reported low HLs, HLs are associated with a social gradient, and there are significant potential effects of HLs on health-relevant indicators. But it is difficult to improve the low HL of people just by offering learning opportunities. For that, people must first be able to accept and attend these offers to learn which is especially difficult for members of disadvantaged or vulnerable groups. Second, in any case it will take time to improve the personal HL of great numbers of people, and third, the relevant content of HL is changing continuously, thus permanent education would be necessary. Fourth, knowledge that is not continuously applied in practice is quickly forgotten. An exception to this is the necessity of offering specific learning opportunity to patients with chronic diseases. But for people in general, it makes more sense to address low HL also or even primarily on the level of the organizations where people make decision and act in relation to their health.

In the US, the concept of the health literate health care organization was developed for that purpose (Brach et al., 2012). Concepts for other kinds of organizations followed (Kickbusch et al., 2013). But, since HL seems to be more relevant for the outcomes of the healthcare sector than for the outcomes of other sectors, and since high proportions of patients are affected by low HL, most of the existing models, instruments and assessment tools still focus on the health care sector. In the meantime, more complex models, and definitions, as well as measurement instruments, have been developed for 'health literate' or 'health literate responsive' or 'health literate friendly' organizations or organizational HL (OHL), respectively. As far as more complex models and instruments are concerned the two newer ones, integrating partly earlier ones, are the Australian organisational health literacy responsiveness framework (Org-HLR) and self-assessment tool (Trezona et al., 2017, Trezona et al., 2018) and the Vienna concept and self-assessment tool (Dietscher and Pelikan, 2017, Pelikan, 2019), in its further developed international version OHL-Hos (International Working Group Health Promoting Hospitals and Health Literate Health Care Organizations (Working Group HPH & HLO), 2019), which takes low HL of its stakeholders not only into account to compensate but also to improve it.

These conceptualizations are based on the relational understanding of HL, meaning that a person's actual HL is not only determined by his or her personal knowledge, skills, and abilities, but also by the demands the person faces in his or her health and healthcare environment when taking and performing health-related decisions and actions. By taking low HL of their users into account, health systems and organizations in diverse sectors can compensate for, or even improve, the actual HL of their users.

The degree to which they can do so depends on relevant features of the organization, such as the availability of trained staff, or the quality of information material offered. In this sense, OHL concepts typically draw on organizational development approaches. Accordingly, to develop OHL, the relevant organizational structures and processes need to be identified and operationalized for measurement to assess, in a first step, the actual OHL status of an organization, which is a precondition to deduct and implement interventions for improvement in a second step. One of the ways to improve OHL would be by integrating the approach into organizational quality management schemes.

Therefore, already in 2022, M-POHL initiated a project in which the international OHL-Hos tool (https://m-pohl.net/sites/m-pohl.net/files/inline-files/SAT-OHL-Hos-v1%200-EN-international_update1.1_1.pdf) is translated, cultural adapted in the participating countries, and piloted in at least one hospital in some participating countries. For primary care/integrated care organizations a generic version (adapted from the OHL-Hos) in English language needs yet to be developed. This work will be continued in the period 2023-2027.

Why should your country participate in the M-POHL project on measuring OHL?

As outlined above, in the long run, OHL seems to be a more effective approach to improving the HL of people than a focus on individual interventions alone. Therefore, M-POHL wants to strengthen the evidence for the approach through supporting countries to measure OHL. In addition, there is at least anecdotal evidence that OHL approaches can help to reduce medical errors, enhance patient safety, and healthcare effectiveness. Thus, the approach appears beneficial for healthcare users and the healthcare system alike.

Countries participating in the project will either get a tool for assessing OHL in hospitals and some support for translating, culturally adapting and piloting it, and/or can contribute to developing a tool suited for assessing primary care services, which then can also be translated, culturally adapted and piloted. Furthermore, there will be an international exchange of experiences with translation, cultural adaptation, piloting, and later for implementing OHL by roll out procedures in the countries. Since the international project is planned as a slow open process, countries can join the project any time, when it fits best for a country, but not later than early 2027.

Workplan of the project on measuring OHL

Building on the experiences and results of the 2022 project, a first step will be to improve, further pilot and finalise the tools on measuring OHL in hospitals and in primary care/integrated care organizations. Therafter, the tools will be translated and culturally adapted to the national languages of the participating countries (respectivley, when this was done in 2022, changes will be integrated in already existing translations). For piloting and rolling out the tools, countries will have to recruit hospitals and primary care/integrated care organizations. On the level of the recruited organizations, data generation will be performed by a two-step self-assessment approach (individal and joint asseessment). To facilitate the work in the participating organizations, supporting tools and training workshops will be provided by the International Coordination Center (ICC). The ICC will also draft an international report that will be finalised together with representatives of participating countries, and will support international and national scientific articles.

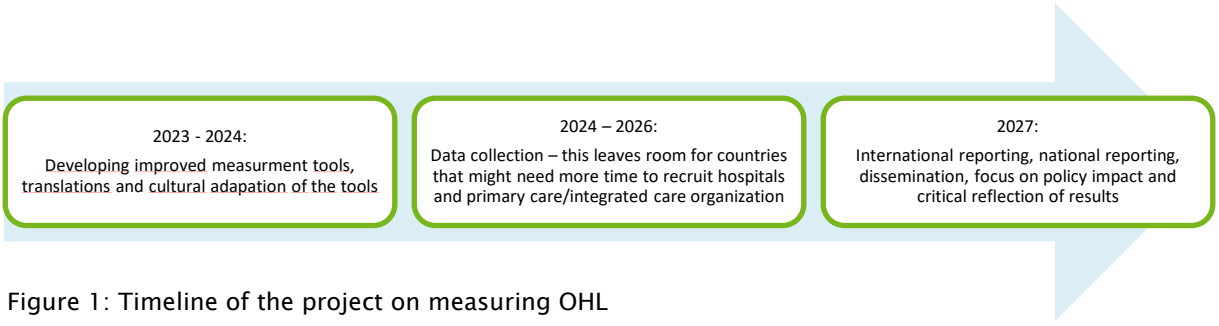

Figure 1: Timeline of the project on measuring OHL

Funding of the project on measuring OHL

The ICC will provide international coordination, administration, and scientific support, which includes to lead the establishing of final measurement tools, research protocols, supporting tools (documents and workshops), oversee data collection, execute international data analysis, coordinate international reporting and editing, and support national publishing. The OHL participating countries will share the costs of the ICC according to their GDP. A first draft on the expected fee for the international support of the ICC was distributed in July 2022.

In addition to the project fee, each participating country will need to ensure funds for the following national activities:

1. necessary translations and cultural adaptions of the self-assessment tools from English into national language(s),
2. coordination and recruiting of organizations for data generation,
3. national collection and analysis of data, publication, and dissemination of national results,
4. (possible) travel costs for participation of national policy representatives and principal investigators in project meetings (at the moment online meetings are planned, but this may change depending on the circumstances),
5. any contributions to the international development of OHL; especially active participation in working groups.

Typically, national participation in the OHL project will be commissioned by a MoH or other public policy body. Financing of the OHL activities needs to be in line with WHO funding rules. This applies to all actors involved in the project. In case of the involvement of none-state actors, they will have to meet the funding criteria outlined in the Framework of Engagement with Non-State Actors (FENSA) (see https://apps.who.int/gb/ebwha/pdf_files/wha69/a69_r10-en.pdf).

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