

The Importance of Being Health Literate: An Organizational Health Literacy Approach

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Abstract

According to Parker and colleagues (2003), a silent epidemic affects the health status of most of the American population, that is to say inadequate health literacy. The same is true in European Countries, where - on average - a third of the population is not able to fully understand, appraise and apply health information as well as to appropriately navigate the health care system (HLS-EU Consortium, 2012). Until today, the attention has been mainly focused on the individual determinants of low health literacy, while studies concerning the health literacy environment (Rudd & Anderson, 2006) and the organizational health literacy (Weaver, *et al.*, 2012) are uncommon. This paper aims at contributing to fill this gap through an explorative research about the tools health care organizations adopt to improve their hosts' health literacy. Drawing from the international literature (Brach *et al.*, 2012; DeWalt *et al.*, 2010; Murphy-Knoll, 2007; Stableford & Mettger, 2007; Matthew & Sewell, 2002) the main approaches to improve organizational health literacy are outlined. Then, a distinction between formal and informal tools to address organizational health literacy needs is suggested and the effectiveness of both of them is compared. The findings of the research suggest that the latter are more common than the former, although they have lower perceived effectiveness compared with formal methods. Health care organizations seem to be still far from effectively activating comprehensive health literacy pathways. Systemic efforts to acquire awareness of the issue and to put in place effective processes of change towards health literacy are strongly needed.

Keywords

organizational health literacy; health literacy; patient empowerment; patient-centered care; patient engagement

1. Introduction: stating “the importance of being health literate”

The “health literacy” concept was introduced several decades ago by Simonds (1974), who argued that health education should be included among the curriculum subjects of all school grade levels with the eventual purpose of improving the individual capability to collect, process and understand health information (Tones, 2002). Indeed, health literate individuals are able to appropriately navigate the health system, achieving better outcomes when dealing with a decline of their physical and/or psychic well-being compared with their low health literate counterparts. Since its introduction, the health literacy concept achieved a wide success, becoming one of the most popular buzzwords both in health care and in the adult education fields (Hamel, 2010; Hill, 2005). Its importance has been further stressed in the last years (Parnell, *et al.*, 2014), to such an extent that it has been widely recognized as a key challenge for health educators (Fetro, 2010).

Health literacy has been usually understood in a restricted sense, indicating the ability to handle the data concerning the protection of the individual health status (Rudd, 2007), such as the instructions contained in prescription bottles, medical recipes and appointment slips (American Medical Association, 1999). Accordingly, health literacy has been articulated in two basic skills, that is to say the comprehension of written and oral health information (literacy) and the expertise to process the numerical data included in the latter (numeracy). The academic literature has joined these two competencies under the epithet “functional health literacy” (William, *et al.*, 1995), that indicates the readiness to perform the every-day tasks related to the management of the health status exploiting the individual knowledge and skills (Smith, *et al.*, 2009; Von Wagner, *et al.*, 2007).

Several scholars have enriched such a narrow definition, claiming that health literacy also concerns interactive and critical competencies, that go beyond functional ones (Wolf, *et al.*, 2009; Pleasant & Kuruvilla, 2008; Rootman & Wharf-Higgins, 2007; Nutbeam, 2000; Nutbeam, 1999). From this point of view, health literate patients are able to effectively take care of their own psycho-physical well-being by processing and comprehending the health information retrieved, as well as by establishing appropriate relationship with the actors that operate within the health system and discriminating the different alternatives available for the protection and the promotion of their health status. Combining these different perspectives, the US Department of Health and Human Services (2000) and the Institute of Medicine (2004) are consistent in defining health literacy as the “*the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions*”, as reported by Baker (2006, p. 878).

From this standpoint, it could be argued that inadequate health literacy is one of the main determinants of the situation of “professional dominance” that usually affects the provision of health care (Freidson, 1970). In case the patient was not able to gather, process and understand relevant health information, the clinician could play a dominant role upon the former, conditioning his/her choices about the health treatment (Ishikawa & Yano, 2008). The same is true with regards to the relationship between the patient and the other categories of health professionals with which he/she interacts during the process of care, here included nursing professionals, who play an important function supporting the orientation of the patients within the health system (Street Jr, *et al.*, 2009). Several problems stem from the condition of supremacy of health care professionals upon the patients, among which: the phenomenon of supply induced demand, that affects the sustainability of the health care system (Phillips, 2005; Hay & Leahy, 1982), and the poor psychological commitment of the patient in the health treatment, that causes a decline in the patient’s compliance with the professionals’ advices and a decrease of the latter satisfaction (Scott, *et al.*, 2000).

In a nutshell, low health literacy deeply interfere with the freedom of choice of the patient, generating both information asymmetries and psychological weaknesses. Such a circumstance is not consistent with the current transition toward a “patient-centered” model of care, that distinguishes most of the western Countries (Barry & Edgman-Levitan, 2012; Epstein & Street Jr, 2011; Stewart, 2001). Indeed, the core idea of patient centered care is that the patient is aware of the provider’s ability to meet health related needs; as a consequence, he/she should be put in the condition of contributing in devising, managing and evaluating the health treatment, by virtue of an informed and continuous involvement (Stewart, 2003).

In substance, the patient-centered approach suggests that the success of health care delivery does not exclusively rely on the skills of the providers. Quite the opposite, the patient is recognized as a key actor in the process, who handles relevant sleeping resources that are generally neglected by health care professionals. To improve the health outcomes that could be achieved, providers should not focus on the mere tasks of rigorously diagnosing the ill-status and devising an appropriate clinical treatment to fix it, in adherence to the traditional bio-medical model (Engel, 2004). Rather, they should empower and engage the patient in the health treatment, acknowledging that his/her contribution is an essential input of health care provision (Needham, 2012). Eventually, the patient is understood as a co-producer of care (Needham, 2008), that is to say as the subject rather than the object of the treatment, who operates shoulder to shoulder with health care professionals.

It follows – both on the side of the demand and of the supply of health care services – *the importance of being health literate* to foster a significant advancement in the outcomes that could be realized within the health care system. The idea of co-production overhauls the role of the patient, re-imagining the latter as a self-manager of his/her health status, who takes part in any phase of the health care provision, from the planning of the treatment to its implementation and to the evaluation of its effects. Poor health literacy hinders the patient’s involvement in the provision of care: on the one hand, it produces a weak commitment of the user, due to his/her perception of the inability to take part in the health care provision; on the other hand, it engenders the worsening of the relationship between the provider and the patient, inciting the former to mistrust the latter and to autonomously guide the health care provision. In these circumstances, poor perceived quality of care is common.

2. Health literacy as a key determinant of well-being

Health literacy has been usually conceived as an “individual trait”, that is to say as a personal feature that concerns any human being (French & Hernandez, 2013). Both scholars and practitioners have presented it as a “silent epidemic” (Clark, 2011; Marcus, 2006), that affects most of the worldwide population (Hls-Eu Consortium, 2012; Pleasant, 2012; Sentell, *et al.*, 2011; Parker, Ratzen, & Lurie, 2003). According to Ishikawa and Yano (2008), inadequate health literacy produces a poor understanding of the individual health condition, thus preventing a prompt and appropriate remedial action to the decline of the individual psycho-physical well-being. Actually, as it could be inferred by Lee, Arozullah and Cho (2004), low literate patients are not willing to seek health information, perceive a low self-efficacy dealing with their own health status, and are not prone to participate in the management of care. In short, health literacy could be conceived as an important explanatory variable of the individual physical and psychic well-being: it predicts poor self-care, improper demand of health care and excessive reliance on health professionals’ advices.

The international literature is unanimous in claiming that health literacy explains the individual well-being more accurately than other relevant factors, such as sex, socio-economic condition, occupation, education level, and ethnicity (Schillinger & Davis, 2005; Weiss, 2005;

Schillinger, *et al.*, 2002). Although there is a weak agreement about the outcomes that could be definitively ascribed to adequate health literacy (Frisch, *et al.*, 2012), several Authors maintain that it produces greater awareness about healthy behaviours and life styles, improves the ability to collect and interpret health information, promotes confident relationships with the health care professionals and fosters the readiness to appropriately navigate the health care system (Moore, 2012; Bush, *et al.*, 2010; McCaffery, Smith, & Wolf, 2010; Abel, 2008; Fineberg, 2004).

According to this perspective, Heinrich (2012) has recently endorsed health literacy as the “sixth vital sign”, along with body temperature, pulse rate, rate of breathing, blood pressure, and pain perception. Consistently, she claims that health literacy should be duly appraised in all clinical practice settings, with the purpose of informing health care professionals about the ability of the patient to effectively deal with his/her disease. Indeed, due to the growing complexity of the health care system, poorly health literate patients run into many hindrances when they access it; at the same time, the ill-status produces a condition of apprehension and uncertainty, that hamper the undertaking of wise choices. From this standpoint, the empowerment of the patient and his/her informed involvement in the health care provision is essential to enhance the outcomes of the health treatment and to limit the risks of inappropriateness in the access to care.

A trend of low health literacy is forecasted for the near future, due to: the steady ageing of the population, the correlated epidemiological transition from the prevalence of acute conditions to the preponderance of chronic diseases, the depletion of social relations among relatives, the consequent fall of informal caregiving, and – last, but not least – the strict specialization of most of the educational curriculum (Parker, Wolf, & Kirsh, 2008). Hence, the launch of wide-ranging initiatives aimed at boosting the individual levels of health literacy is crucial. By virtue of the adsorption of stronger competencies in regards to the management of the individual health status, patients are able to make informed decisions about the resources available to protect and promote their well-being; as well, they are able to discern the various determinants of health, promptly and effectively counteracting the risk factors that affect their social functioning (Chinn, 2011; Nutbeam, 1999).

In the prosecution, a brief exposition of the main tools suggested by the literature to appraise and improve individual health literacy will be depicted. Then, the inadequacy of the latter will be discussed, assuming that health literacy could not be dealt with as a mere individual trait. Accordingly, the concept of organizational health literacy will be introduced, reminding that health care organizations should play a significant role in improving the ability of their users to appropriately navigate the health system, fostering their functional, social and critical competencies. After a description of the most popular approaches directed at enhancing the organizational health literacy, the results of an empirical study realized in the Southern of Italy are showed; drawing from them, some theoretical insights and practical implications are discussed, paving the way to further developments.

3. The measurement of health literacy as an individual trait

As it might be inferred from the above discourse, health literacy is an essential ingredient in the recipe for a more effective and sustainable health system. On the one hand, health literate patients are able to achieve better health outcomes, since their expertise to retrieve and process health information contributes in the enhancement of the treatment quality. On the other hand, health literacy paves the way to the reduction of improper costs, due to the higher appropriateness in the access to care. With particular regards to the last point – even though scholars are not unanimous dealing with the impacts of inadequate health literacy on costs, as

argued by Eichler and colleagues in a recent literature review (2009) – several empirical studies show that low health literate patients generate greater expenditures compared with their high health literate counterparts, first of all because of the wider risks of impropriety when they demand care and the stronger likelihood of unhealthy behaviours in their everyday life activities (Weiss and Palmer, 2004).

Indeed, patients who disclose low health literacy are more willing to state an ill-status and to express demanding requests of care, addressing most of their claims toward urgency and/or emergency services (Howard, Gazmararian & Parker, 2005; Baker, *et al.*, 2002; Gazmararian, *et al.*, 1999). They usually show poor compliance with the health care professionals' instructions and are inclined to undervalue the importance of environmental, social and economic determinants of health, being exposed to a larger amount of factors that negatively affect their well-being (Tarn, *et al.*, 2006; Hwang, Tram & Knarr, 2005). Last but not the least, inadequate health literacy produces higher rates of hospitalization (Wolf, Gazmararian & Baker, 2005; Williams, *et al.*, 1998). On the one hand, the higher costs associated with the patients' institutionalization lead to the worsening of the health care balance deficit; on the other hand, the bias toward hospitalization engenders the decline of the served population well-being, particularly when the latter is mainly affected by chronic conditions, producing a decline of the perceived quality of care (Cavanaugh, *et al.*, 2008; Baker, *et al.*, 2002).

From this standpoint, several scholars maintain that inadequate health literacy constitute a significant burden for the health system. Patients who are not able to protect and promote their health status leveraging on their capability of appropriately collecting and processing health information produce a volume of expenditure that exceeds 20% of the costs generated by health literate patients; in the worst-case scenario, this gap could reach even 50% (Vernon, *et al.*, 2009; Howard, *et al.*, 2005; Friedland, 1998). Such a discrepancy withstands even when confounding factors – like age, sex, seriousness of the disease, and incidental complications – are appreciated (Wieser, *et al.*, 2008).

Drawing from these data, the relevance of health literacy as a key determinant of the quality of care and of the health care system's long-term sustainability is undeniable. Nevertheless, it has been generally understood as an individual trait rather than as a variable that concerns all the actors involved in the provision of care. From this point of view, health literacy has been unfrequently perceived as an organizational issue; both scholars and practitioners have focused their attention on the "one to one" relationship between the patient and the health care professional with the purpose of diagnosing health literacy and analyse its effects on the appropriateness of the health care provision. As a consequence, most of the tools to assess health literacy – such as the *Test of Functional Health Literacy in Adults* (ToFHLA), also available in its short format (s-ToFHLA), the *Rapid Estimate of Adult Literacy in Medicine* (REALM) and the *New Vital Sign* (NVS) – concern the individual ability to read and interpret health information, without affecting the organizational context where the interaction between the patient and the health care professional is carried out (Shah, *et al.*, 2010; Morris, *et al.*, 2006; Parker, *et al.*, 1995; Davis, *et al.*, 1993).

In adherence to this perspective, health care professionals have paid inadequate attention to the organizational determinants of health literacy; indeed, they have solved it as a relational matter, that is to say as a phenomenon that solely relies on the providers' ability to impart health information and to make them understandable to the patients. Accordingly, most of the tools that have been devised with the purpose of weakening the impacts of low health literacy are aimed at balancing the relationship between the patient and the health care providers, enhancing the transfer of information. The *teach back*, the *Ask Me 3™* and the *show me* methods are illustrative examples of such an approach to health literacy (Six-Means, *et al.* 2012; Sudore & Schillinger, 2009; Kripalani, *et al.*, 2008; Miller, *et al.*, 2003; Schillinger, *et al.*, 2003). On the one hand, it allows a timely action on the patient in order to address his/her

inability to process health information; on the other hand, it does not depict the complexity of the health literacy determinants, showing a poor effectiveness.

4. The role of health care organizations in the improvement of health literacy: an organizational health literacy approach

Since health care organizations host most of the interactions between patients and health care providers, they are the fittest context to enhance the former ability to handle health information and to appropriately navigate the health system (Koh, *et al.*, 2012). Nevertheless, to boost the individual and collective levels of health literacy it is not enough to launch specific and unconnected actions within health care organizations. Quite the opposite, the latter are urged to include health literacy within their strategic planning, assuming it as a core value that inspire their operations and as a driver of the quality of care (Thomacos & Zazryn, 2013). According to this perspective, health care organizations are called to embrace a *patient centred* approach to care, with the eventual purpose of supporting the orientation of the patients who deal with the health care system. Despite its topicality, empirical studies aimed at discussing the commitment of health care organizations to meet the needs of low literate patients are uncommon; as well, the tools aimed at enhancing *organizational health literacy* are still poorly debated in the academic literature (Weaver, *et al.*, 2012).

Scholars seem to prefer an incidental approach to organizational health literacy, focusing their attention on specific interventions devised by providers to address the needs of the patients who exhibit inadequate health literacy. As an example, dealing with organizational health literacy Matthews & Sewell (2002) consider discrete organizational efforts to meet the demands of poorly literate patients, concentrating their concern on the functional dimension of health literacy. More into details, they discuss the interventions directed at the enhancement of the readability and intelligibility of the health information, paying poor attention to the human resources commitment toward an organizational health literacy approach. In general terms, a systemic understanding of the role played by health care organizations to address poor health literacy is still lacking (Nielson-Bohlman, *et al.*, 2004).

Nevertheless, the transition from *health care organizations* toward *health literate health care organizations* calls for a radical process of change, that involves both structural and cultural impacts. Beyond the enhancement of the friendliness of informational tools (Ratzan & Apfel, 2011), health literacy should be conceived as a core value that informs both the strategic and the operational planning of providers (Koh, *et al.* 2013; Weaver, *et al.*, 2012). According to this perspective, health literacy should be meant as an organizational issue rather than as an individual trait, that should be duly contemplated in structuring health care organizations (Brach, *et al.*, 2012). As stated by the World Health Organization (1986), health care organizations should adhere to a *setting-based approach*, according to which they should promote health literacy within their boundaries, with the purposes of:

- improving the ability of the patients to navigate the health care system;
- enhancing the integration between health and social care;
- abating the rates of hospitalization and promoting self-care;
- improving the access to care of the disadvantaged classes of the population, with particular reference to ethnic minorities;
- advancing the friendliness of health information.

In an attempt to identify the distinguishing features of *health literate health care organizations*, Brach and colleagues (2012) have devised ten attributes that the providers of care should maintain to be perceived as friendly by their users, drawing them from several empirical observations. According to their proposition, health care organizations have to

create an environment that enables patients to optimally access and benefit from the services provided, making it easier for the latter to collect, process, understand, and use the health information retrieved. First of all, a health literate health care organization should be provided with committed leaders, who make health literacy integral part of its mission, structure, and operations. In this way, it is possible to integrate health literacy in the management of health care organizations, including it into strategic and operational planning, evaluation activities, patient safety concerns, and quality measures. For this purpose, health care organizations have to prepare their human resources, in order to make them aware about the impacts of poor health literacy on the outcomes of health care provision. Besides, the served population itself should be included in the design, implementation, and evaluation of health information and services, in order to boost the total impacts of these interventions.

By virtue of such a comprehensive approach to care, it is possible to meet the needs of the patients with poor health literacy skills, while avoiding stigmatization. On the one hand, health literacy strategies are employed in interpersonal communications, confirming users' understanding at all points of contact; on the other hand, easy access to health information is disclosed to the patient, with the purpose of supporting them in navigating the health system. Last, but not the least, health literate health care organizations strive for enhancing the comprehensibility of health information they provide, designing and distributing print, audio-visual, and social media contents that are easy to understand. In particular, health literate health care organizations are able to: clearly communicate what health plans cover and what services are financed out of pocket, address patients in high risk situations, where psychological weaknesses and professional dominance are common, and foster self-care.

Consistently with this conceptual framework, Wynia and Osborn (2010) suggest a multi-faceted tool to measure the levels of organizational health literacy, named *C-CAT* (*Communication Climate Assessment Toolkits*). It concerns nine dimensions, that are employed to assess the organizational health literacy intensity, that is to say: leadership commitment, information collection, community engagement, workforce development, individual engagement, socio-cultural context, language services, health literacy, and performance evaluation. Each dimension is evaluated both from the perspective of health care professionals and from the point of view of patients, to globally check the *friendliness* of health care organizations and to identify prospective actions to improve it. Obviously, inadequate organizational health literacy is associated with poor health care organizations friendliness; both of them generate the perception of low quality in the provision of care.

Eventually, health literacy is conceived as a complex issue, that concern the health care system in its entirety, rather than the one-stop interaction between health care professionals and their patients (French & Hernandez, 2013). From this standpoint, organizational health literacy could be framed according to the *STEPP* approach (*Sharing, Technology, Evaluation, Partnership, Participatory*), as suggested by the U.S. Department of Health and Human Services (2010). It stresses the urgency of programmes and information sharing, the importance of technology, the need to evaluate the outcomes of plans and programmes, the convenience of inter-organizational relationships, and the usefulness of the involvement of the served population. In the prosecution, an empirical study that fits with this theoretical framework is described; drawing from its findings, some reflections about the effectiveness of the most common methods to address organizational health literacy are argued, suggesting their grouping in formal and informal procedures.

5. An explorative study to assess the effectiveness of organizational health literacy

5.1 Methodology

Although the impacts of inadequate health literacy on the health outcomes have been widely acknowledged among scholars, the awareness about its organizational relevance is still poor. Notwithstanding, as it could be argued from the above discourse, health care organizations are assumed to be the most fitting context to address the health needs of low literate patients. According to this perspective, the recognition of health literacy as a key organizational issue is a significant intermediate variable between adequate health literacy and better health outcomes. Indeed, health literate health care organizations support the patients in navigating the health system, steering them toward timely and appropriate care. From this standpoint, this study is aimed at providing some exploratory insights about the providers' awareness of the organizational relevance of health literacy; at the same time it tries to examine how health literacy is addressed within health care organizations.

A convenient and non-representative sample of health care professionals operating in a Southern Italian region has been selected, consisting of general practitioners, specialists, nursing professionals, chemists, biologists, and clerical workers who attended at a master course in health management that contained a module on health literacy. Hence, the subjects involved in the research shared the same educational background about health literacy, being informed of the impacts of poor health literacy on both the health outcomes and the sustainability of the health care system. They acted as key informant to collect data about the awareness of organizational health literacy and the effectiveness of the tools employed within health care organizations to address the needs of poor health literate patients. On the whole, 40 health care professionals were included in the sample, coming from all the kinds of health care organizations operating within the Italian National Health Service.

First of all, they have been involved in a training activity about organizational health literacy; at the beginning, some conceptual issues have been dealt with, providing the former with the basic concepts of organizational health literacy and with the tools to appraise it. A month later, a test to assess the competencies in the field of organizational health literacy acquired has been administered to the health care professionals; in the light of the performance achieved by them, some in-depth lectures have been provided, in order to fill the knowledge gaps of the subjects involved in the traineeship. Then, the health care professionals have been invited to take part in an explorative survey about the level of *health literacy friendliness* of their belonging organizations; all the professionals who attended at the training course accepted to participate in the survey.

Drawing from the C-CAT methodology, a dedicated questionnaire has been devised by the Authors with the purpose of appreciating the perceived willingness of health care organizations to acknowledge health literacy as an organizational issue as well as to carry out initiatives directed at improving the ability of the patients to navigate the health system. The tools employed to enhance health literacy in the organizational context have been classified in two categories, concerning, on the one hand, *formal* initiatives, that is to say explicit activities directed at supporting the patient in navigating the health system, and, on the other hand, *informal* initiatives, that is to say voluntary actions provided by health care professionals to back poor literate patients.

According to the C-CAT benchmark, the survey consisted of a structured questionnaire, linking a five-point Likert scale to each question. The attention has been focused on five out of the nine dimensions of the toolkit proposed by Wynia and colleagues (2010), the combination of which provide several information about the friendliness of health care organizations toward low health literate patients: the organizational *commitment* toward the enhancement of health literacy; the *engagement* of health care professionals in the promotion

of organizational health literacy; the *involvement* of the larger society (included municipalities, educational institutions, patients and their informal caregivers) in the efforts aimed at improving health literacy; the tools and the methods used to assess health literacy; the evaluation of the initiatives directed at the enhancement of organizational health literacy.

As anticipated, this research has been conceived as a preliminary study, aimed at collecting some exploratory insights about organizational health literacy. In particular, it is proposed at bringing some reflections about the awareness of health care professionals about the organizational relevance of health literacy and about the tools that could be employed to address low health literacy within health care organizations. Eventually, the findings of this study will inform further and more reliable empirical analysis.

5.2 Findings

The findings of the research disclose a considerable irregularity within each of the five dimensions of the survey, suggesting several anomalies in the management of organizational health literacy. In addition, the variability between the five dimensions is noteworthy, implying the lack of a systemic approach to address low health literate patients within the health care organizations involved in the study. Indeed, the health care professionals who participated in the research stated that the organizational commitment toward the health literacy issue is generally weak. Most of them (two out of three subjects) perceive that the efforts of their belonging organizations – in terms of policies, planning and programmes aimed at enhancing the friendliness of the organizational context – are inadequate. Health care organizations lack a strategic orientation toward the improvement of health literacy, due to the shortage of awareness about the impacts of the latter on both the health outcomes and the sustainability of the health system. It follows an insufficient allocation of financial resources to boost the organizational communication.

The health care professionals are consistent in declaring that their belonging organizations are not willing to meet the health needs of poor health literate patients: three out of four affirm that their belonging organizations do not carry out any intervention to comply with the demands of care of patients with inadequate health literacy. None of the participants to the survey declares to be aware of the utilization of tools to assess the individual and the organizational health literacy; as a consequence, health care organizations do not have any information to instruct the organizational policies in regards with poor health literacy. In most of the cases, health care organizations are not provided with specific tools to assess the performance of health care professionals who deal with low literate patients; nonetheless, some of the latter state that their managers informally incite them to create a friendly environment for low literate patients, facilitating their orientation within the health system. Consistently, informal tools to address organizational health literacy are more common than formal ones.

Looking at the engagement of health care professionals in the promotion of organizational health literacy, four out of five of them maintain that they are not aware about the role played by their belonging organization to address the health needs of low literate patients. Indeed, health care organizations do not usually arrange training meeting to enhance the awareness of organizational health literacy among their human resources. Despite the poor attention paid by health care organizations toward the improvement of the competencies of their human capital about health literacy, most of the professionals interviewed claim to accomplish spontaneous efforts directed at meeting the information needs of the patients who exhibit inadequate health literacy. Consistently, health care professionals deem that informal tools to promote organizational health literacy are more timely than formal ones.

According to the subjects involved in the research, health care organizations seem to be detached from their community. One out of two health care professionals interviewed states

that health care organizations do not enlase any relation aimed at promoting health literacy with the entities that populate their environment, such as educational institutions and municipalities. Quite the opposite, the community involvement in the initiatives directed at enhancing the organizational health literacy is almost absent; at the same time, nor the patients nor their informal care-givers participate as informants in the planning of the activities proposed at the improvement of the health care organizations friendliness.

With regards to the methods and the tools employed to assess health literacy, most of the health care professionals declare that their belonging organizations solely focus their attentions on the individual ability to comprehend health information; accordingly, the *teach back method* is the most employed tool to appreciate the patients' health literacy. On the other hand, the efforts aimed at gauging the organizational health literacy are uncommon. It could be argued that the *teach back method* is employed as an informal practice by health care professionals in their relationship with the patients, lacking any organizational guideline; indeed, such a tool is usually used to fill the communicational gap between health care professionals and patients, enhancing the compliance of the latter. On the other hand, tools aimed at promoting the ability of the patients to navigate the health system are uncommon.

Dealing with the formal instruments arranged by health care organizations to inform and address their patients – among which: informed consent models, corporate communication materials, educational tools aimed at promoting the individual well-being, and the organizational devices to enhance the accessibility of the structure (*e.g.* maps, signals, directions, etc.) – health care professionals are concordant in stating that they are poor friendly and hard to comprehend. As well, health care professionals assert that health care organizations do not employ any method to assess the users' ability to understand the information provided and to process them.

Last, but not the least, the evaluation of the policies and interventions directed at the enhancement of organizational health literacy has been appreciated. In particular, the attention has been focused on the perceived effectiveness of the efforts toward the advancement of organizational health literacy. The interviewed health care professionals perceive a poor effectiveness of the actions planned by health care organizations to meet the needs of low health literate patients; moreover, they indicate that the disintegration of the interventions aimed at the enhancement of organizational health literacy impoverishes their impacts on the health outcomes achieved. One out of two interviewed professionals claims that the attention paid by health care organizations toward health literacy is fragmented and unproductive, when not lacking.

6. Discussion: the effectiveness of formal and informal approaches

According to the findings of the research, the following assumptions could be held:

- the health care organizations included in the research are still far from launching wide formal interventions aimed at enhancing organizational health literacy;
- moreover, the health care organizations involved are not *health literacy oriented* and they are usually not able to contribute in the promotion of the individual well-being;
- despite this, health care professionals are aware of the impacts of poor health literacy on the health outcomes and they are committed in addressing it;
- indeed, informal approaches are common among professionals, counterbalancing the inertia of health care organizations;
- when launched, professionals consider insufficient the formal policies devised by health care organizations to inform poor health literate patients;

- nevertheless, in the light of the current epidemiological transition, the engagement of health care organizations towards the enhancement of organizational health literacy is essential.

Drawing from these findings, two approaches to foster organizational health literacy could be envisaged: formal and informal ones. In the prosecution, their frequency of employment and perceived effectiveness in the opinion of the health care professionals are discussed; in particular, with regards to the last point, the Authors assessed the perception of the latter about the quality of both formal and informal tools to address organizational health literacy. With regards to formal approaches, the attention has been focused on the perceived effectiveness of: the inclusion of organizational health literacy in the strategic planning, the allocation of adequate financial resources to enhance organizational health literacy, the arrangement of specific training programs in the field of health literacy, and the establishment of formal artefacts to improve the patients' orientation within health care organizations. With regards to informal approaches, the Authors contemplated: the professionals' sensibility to improve the friendliness of health care organizations, their inclination to informally support patients with low health literacy, and their disposition to employ the teach back method or similar tools to enhance the patients' understanding. The correlation between both formal and informal approaches and perceived effectiveness was then measured.

Table 1. Frequency of formal and informal procedures and perceived effectiveness (0=minimum; 100=maximum)

Dimensions	Average	STD DV	Correlation
Formal procedures	47,92	16,00	
Informal procedures	63,47	15,80	
Total effectiveness perceived	47,90	16,41	
Formal procedures - perceived effectiveness			0.81
Informal procedures - perceived effectiveness			0,08

Source: Authors 'elaboration

As shown in Table 1, informal procedures to address organizational health literacy are more common than formal ones. On the other hand, formal procedures are perceived as more effective than informal ones. It could be assumed that health care professionals undervalue the impacts of their initiatives to support patients with low health literacy when health care organizations do not adopt a systemic approach aimed at enhancing their friendliness toward the latter. Indeed, health care professionals' efforts to adopt informal procedures are thwarted when they perceive to be not backed by their belonging organization.

7. Conclusions

The findings of this study lead to several observations about the health care organizations' ability to communicate. In general terms, it could be assumed that health care organizations are poorly health literate: they do not include health literacy in their *corporate identity*, nor contemplate the impacts of low health literacy in their strategic planning and organizational programs. Dealing with inconvenient informative tools, patients are not able to navigate the health system, thus negatively affecting the quality and appropriateness of care. Health care professionals are committed in addressing low literate patients' health needs; however, if not backed by health care organizations, the impacts of their actions turn to be poor.

Despite health literacy is widely acknowledged as a key determinant of health care quality and the enhancement of organizational health literacy is generally conceived as an essential

ingredient in the recipe for the paradigmatic transition from *care* to *well-being*, it seems evident that the attention paid to it by health care organizations is still poor. On the other hand, an effective health care health literate organization necessarily arises from a re-interpretation of the logics entailed in its strategic, tactical, and managerial construction, as well as from a reconceptualization of the health care pathways in a perspective of integration with the patients and with the wider society.

In an attempt to conceive a still lacking definition of organizational health literacy, we could argue that it should be meant as a systemic approach, that concerns health care organization as a whole. It demands a strong organizational involvement, that affects the health care organizations' mission, vision, strategy, human resources management, and daily operation. Besides, health literate health care organizations are outside oriented, since they identify in the community the foundation of their health governance approach. Health literate health care organizations operate as critical hubs within the health system: the fundamentals of health care promotion and prevention are fully experienced within them, with the purpose of enhancing the quality of health care and improving the health outcomes achieved.

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