

INVITED EDITORIAL

Health literacy in Aotearoa New Zealand – what every medical student needs to do

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Health literacy is our ability to manage our wellbeing at a particular point in time given the range of demands placed on us by the way the health system and health services are organised and delivered. These complex demands also include how access to health professionals is controlled and how health information is provided.

It can be useful to think of health literacy as a dynamic state of knowledge, skills, and cognitive space relative to need. This helps us to recognise the ever-changing knowledge, skills, and cognitive space we need to manage our wellbeing through life. This dynamic state can also describe our wellbeing at an individual and whānau level with people experiencing many health changes over a lifetime, and disease understanding, treatment and prevention advice continuing to evolve. These constant changes to our health system and within our personal experiences means *every person will have health literacy needs at some point*.

Think about the knowledge and skill demands created by the coronavirus disease 2019 (COVID-19) pandemic at the start of 2020. This was challenging for everyone. The initial challenge was understanding the disease, risks and spread. However, it quickly became a challenge of keeping up with changing messages, assessing the credibility of information, adhering to unfamiliar health practices, and trying to work out the meaning of new terms such as coronavirus, bubbles, vaccine mandates and r-factors. We needed to estimate our personal risk, manage isolation, avoid health care while still managing our health, and decide whether we were essential or not. And that was just in April.

The concept of health literacy demands is well described in the preamble to the Ministry of Health's "Framework for Health Literacy."¹ Health conditions such as asthma and journeys such as accessing and navigating health services create health literacy demands.^{2,3}

Health literacy is not a fixed set of knowledge and skills that can be pre-learned to cope with any situation we might face. For example, we don't all learn about arthritis just in case we get it at some stage of our lives.

The concept of health literacy first emerged in the United States of America (USA) in the 1970s where any readmission or failure to recover from surgery posed a legal and financial risk to hospital systems and the health professionals who worked in them. As a result, health literacy was defined as something people lacked, so that the individual could be partly blamed for the risk. This deficit description of health literacy has been almost universally adopted worldwide and most research articles will reflect this view.

New Zealand's "Framework for Health Literacy"¹ contains a much more sophisticated definition which recognises that a deficit concept of health literacy is inaccurate, inequitable and contributes to bias in the health system.

Describing people and certain populations, such as whānau Māori, Pacific peoples, migrants, and refugees, as having low health literacy is inaccurate. In fact, most people would describe their health liter-

acy as perfectly adequate to meet their current needs and this will only change when their health needs, health advice, or health services change, as it did with COVID-19.⁴

Our work in health literacy has given us the opportunity to work with a wide range of organisations and services. Often, we are asked to help with service improvement projects focused on improving equity outcomes for example, reducing rates of people not attending outpatient services, improving diabetes management, or increasing the number of live kidney donors. We are asked to participate in these projects because organisations often believe that people have low health literacy which is contributing to poor decision making and health behaviours. We get to investigate the patient journey, observe clinical and service interactions, and interview service providers as well as individuals and whānau about their decisions and perspectives. We find low health literacy is seldom an issue. Rather people have behaved in ways entirely consistent with the messages they have taken from the health services, staff, and written information. People believe they are doing the right things for their health or are trying to do the right things but have encountered system or service barriers such as not being told about options because of cost. The barriers we see to improving health are not people with low health literacy, but services and organisations failing to meet the entirely reasonable and easily anticipated information needs of their communities.

We have to be careful not to dismiss people's behaviour as being due to low health literacy. Health literacy is not determined by intelligence, ethnicity, language, education, or income status. You cannot make assumptions about who will have health literacy needs and who will not.⁵ People's understanding of their health is determined by many things including their experiences, priorities, interests, stress levels, resources, guidance, and the quality of communication they have received. It is reasonable to expect that part of delivering health care is effectively identifying and meeting any health information and skill needs people have. In Aotearoa New Zealand this is described as providing health literate health care.¹

A health literate approach to health care

What does it take to identify and meet the health literacy needs of people we work with? We need to provide health services that enable people to grow their knowledge and skills in relation to health when it is relevant for them, and in a way that is effective for them. Every health discussion needs to appropriately identify and meet people's health literacy needs.

We developed a health literacy communications model for personal interactions for the Health Quality & Safety Commission — Three Steps to meeting health literacy needs | Ngā toru hīkoi e mōhiotia ai te hauora (Three Steps).⁶ The Three Steps is based on adult learning principles. Using the Three Steps effectively requires careful, empathetic listening to fully understand people's perspectives.

As most health communication is oral, to meet health literacy needs you need to be a good listener. Showing you are listening to people will also build their trust and a willingness to share.

THERE ARE TWO TYPES OF LISTENING:⁷

1. **Listening to reply** such as getting ready to make a diagnosis or answer a question. Once you start listening to reply, you are thinking more about what you are going to say, and less about what the other person is saying. This means you stop listening.
2. **Listening to understand** is when you are focused on the messages a person is sending to help you understand their thoughts and feelings. These messages will include words as well as tone, mood, expressions, and body language.

When using the Three Steps you will be mainly listening to understand, because you are trying to better understand the knowledge, feelings, and perspectives of the other person.

The Three Steps model

1. **Ask** questions to find out what a person knows, believes, feels, wants, can do (their picture)
2. **Build** knowledge and skills by connecting to what a person already knows to grow their picture about their health
3. **Check** you have been effective at Step 2

The Three Steps provides a process to follow with people in every health discussion. Using the Three Steps will make sure your discussions are effective for people. The Three Steps support focused and tailored care in the time available. The Three Steps also support better self-management, fewer complications and readmissions, as well as stronger relationships.

Most importantly the Three Steps support improved equity outcomes by providing a way of tailoring health care to an individual or whānau. As you will be aware there are many different aspects to the significant inequities in health outcomes that Māori experience, including colonisation, socio-economic disadvantage, a greater burden of long-term conditions, an increased risk of more serious health outcomes, as well as poorer access to, and quality of health care received.⁸ As a communication process, the Three Steps start by identifying what people know, believe, feel, and want for their health. This provides clear guidance to those working in health about the responses needed in order to be patient and whānau centred, rather than disease or treatment centred. The Three Steps also define the effectiveness of health interactions as being determined by the patient and whānau experience of having their needs met, rather than by the judgement of those delivering health care services.

The Three Steps also support working in a culturally safe way by providing an opportunity to identify with people their values and beliefs about health so that ongoing discussions can reflect and respect these perspectives.

As a communication process, the Three Steps can be used with the Hui Process (familiar to all medical students in Aotearoa New Zealand) to provide structure to a clinical discussion.⁹ The Hui Process and the Three Steps can be combined as described in Table 1. Incorporating the Hui Process and the Three Steps is ideal because the Hui Process emphasises the importance of establishing a relationship and building rapport with a person or whānau before focusing on identifying the reasons for meeting and kaupapa for the visit. Establishing respect and trust at the start of a discussion is essential to the open sharing of information in the Three Steps.

The Three Steps can be aligned in a similar way with other communication models used by health professionals such as the Calgary-Cambridge communication process.¹⁰

Table 1: Combining the Hui Process and the Three Steps to Meet Health Literacy Needs⁶

The Hui Process	The Three Steps
<i>Mihi</i> : Initial greeting and engagement	
<i>Whakawhānaungatanga</i> : Making a connection	Step 1: Ask questions to build rapport and get to know more about a person and what is happening in their life
<i>Kaupapa</i> : Identifying and focusing on the main purpose of the encounter	Step 1: Ask questions to find out what the person thinks, knows, feels, and believes including setting an agenda Step 2: Build new skills and knowledge onto existing skills and knowledge Step 3: Check you have been clear as each piece of new information is added
<i>Poroporoaki</i> : Concluding the encounter	Step 3: Check you have been effective as part of a final recap by identifying the key messages and actions from the discussion

THE THREE STEPS HELP

- > You uncover what people already know, believe, feel, want, and can do (Step 1)
- > You begin to understand their worldview (Step 1)
- > People you are talking with to recall their prior knowledge so they can make connections with the new information you give them (Step 1)
- > You plan how much information you will give people and in what order (Step 2)
- > You check you have been clear, and people have had their health and information needs met (Step 3)

Step 1 is all about asking good open questions that encourage people to describe their understanding and thoughts about their wellbeing. This is known as activating prior knowledge which helps people reflect and get ready to take on new information.¹¹ Along with identifying existing knowledge, open questions can help you understand people's perspectives on health and wellbeing. Step 1 is also your opportunity to confirm and acknowledge the prior knowledge people have.

A lot of the questions asked in health tend to be closed questions, seeking specific information, e.g. "How long have you had this pain?", "How bad is it?", "What have you tried?" These questions are essential for diagnosis but do not reveal enough about people's knowledge, beliefs, and feelings to provide health literate, patient and whānau-centred care.

FOR EXAMPLE: OPEN QUESTIONS AND CONVERSATION STARTERS

- > What has been going on for you?
- > Why did you come to see me today?
- > What is worrying you?
- > What has changed since we last met?
- > Please tell me about how you've been feeling.

TO EXPLORE MORE

- > Please tell me more about your diabetes
- > What have you been told about your condition?
- > How do you feel about that?
- > What have you tried so far?
- > What do you think might work?

The responses to the open questions you ask will help you work out what people know and don't know, thereby saving time by avoiding telling them things they already know which potentially could stop

them listening. People's responses will give you their prior knowledge to which you can connect new ideas, as well as an appreciation of people's priorities or concerns to focus the discussion.

By asking questions, you will sometimes find people have outdated knowledge or beliefs about their health. To add new information, you are going to have to discuss the outdated knowledge in a way that recognises people may have held this knowledge for a long time and have valid reasons for believing this knowledge to be accurate. Often this knowledge has been received from trusted sources such as friends and family, or through social media. If you only add new information without addressing outdated knowledge, people are more likely to dismiss or forget the new information because it doesn't fit with what they already know. In the same way, people are less likely to act on information that conflicts with what they already know and believe. To help address these differences, ask permission to share and if possible, explain the connection between old and new information e.g. "Is it okay if I share with you some of the new information (or new research) we now have about this condition?"

In Step 2 you help people build new knowledge and skills by providing new information and demonstrating skills in ways that connect to people's prior knowledge, while being careful not to overwhelm.

Part of building knowledge is ensuring people understand and can use essential health terms. Terms need to be said clearly and explained using plain language initially, followed by repetition of the terms and explanations throughout the discussion, and later checked at Step 3. People need to hear a new word multiple times before they feel comfortable using it.¹² Try reflecting the words the person has already used within your explanation of a new term. You could also write down new words, including a phonetic version showing how to say them, or underline or highlight the terms in written material. For example, you might say "gall bladder operation" before introducing the clinical term "cholecystectomy" and then write down the spelling and pronunciation "coly-sis-tek-o-me." Avoid dumbing down language, for example the phrase "you had a turn" has no place in health care unless you are providing directions. Also avoid relying on clinical terms to soften a message or reduce alarm. For example, people need to know they could have cancer rather than "you have a mass" or "indication of malignancy."

Health is also full of non-essential terms that should not be used with people as this creates unnecessary complexity e.g. stool sample and menstrual cycle.

Using visuals to support your explanations can be helpful as our brains can often recall simple visual information better than written or spoken information. Pictures and diagrams are particularly effective at helping people understand sequences and difficult and unfamiliar concepts, such as how the body works. Pictures and diagrams also have greater emotional impact than words alone.

If you give people written information to refer to later, discuss these materials with them beforehand so they are more likely to refer to the information again. Explain why the material might be useful to them by describing and locating the useful information. Personalise and make the information more meaningful by highlighting, underlining, circling, or numbering key sections.

Helping people anticipate the next steps in their health journey is an important part of building health knowledge. This could be what to expect from a new medicine or treatment or explaining the reasons why people should contact you again, or what a referral process involves so they know if things are on track. Explaining the possible next steps people can expect with their health, helps people better navigate the system, have their questions answered, understand how long it could take for their condition to change and be better prepared for any changes they might experience.

As part of building knowledge and skills, be careful with the idea of "patient education." For a lot of people, patient education involves telling people what they should do with no regard to their situation or their ability to make those changes. This telling can often be perceived as telling off.

As a result of your recent experiences of school and university, you might equate education and learning with an expert explaining a topic. While this is a small part of what happens, we tend to forget all the other things we had to do to learn about a topic. Think about the homework and reading, the demonstrations, discussions, experiments, making errors and corrections and endless practice with feedback, assignments, and tests. Think about how each piece of information was discussed at length and more pieces were added over many months or years until you understood the whole picture. Hearing a message once or twice from an expert will rarely be enough to meet anyone's health needs.

Learning for adults includes many of these same activities but they happen in the context of people's busy lives where health may not be a priority. You cannot assume people will take on information in the first instance, so provide backup sources such as the Health Navigator website. While people are with you, ask them to open the website on their phone and show them how to navigate to the page that is relevant and bookmark it for them.

Finally, and most importantly, you need to use Step 3 and check that your attempts at building knowledge and skills have been effective. This means confirming that people now know the most important messages you are trying to provide i.e. that you are doing a good job in activating (Step 1) and building (Step 2).

Step 3 is not a test of how well people have understood you. Instead, it is checking how clearly and effectively you communicated. The responsibility for your effective communication lies with you.¹³

Checking you have been clear is about seeking specific information and feedback from people you have been talking to. This means people have what they need to manage their wellbeing. You could ask people to say, in their own words, what they now need to do. For example, you could say "We have discussed a lot today. To make sure I didn't miss something out, would you please tell me the key actions we agreed on?" Or "I just want to check I have been clear, tell me what you are going to tell your whānau when they come in today."

If you find that people do not recall some of the information you have given them, think about what you said that wasn't clear for them. Was there a problem with the language you used, or maybe you gave too much information at once? Or perhaps the person was too unwell to take on much information. At this point you can go back to Step 2: Build and explain the missing information again, using a different approach e.g. using visual reminders to help people. Say "I am sorry I wasn't clear, let's go over that again". Remember, Step 2 is about you providing the right information in the right way for people.

If you do not carry out a thorough check at Step 3, you have no idea if people have what they need to manage their health. Don't use questions such as "Do you have any questions?" or "Does that make sense?" or "Do you understand?" These questions are not accurate ways of checking you have been clear. Under the Code of Rights you are responsible for effective communication.¹³

What can medical students do to provide health literate care?

At this stage of your career, you have more time with people, so practise your skills using the Three Steps and the Hui Process so these become automatic for you.

Develop a few open questions to use at Step 1 to encourage people to share their knowledge, beliefs, feelings and priorities.

Remember to listen to understand — not just to what the person is saying but also how they are feeling. Respond with empathy to the feelings you hear.

Develop one or two questions for Step 3 that generate the key details people have taken from the conversation to determine whether you have communicated clearly.

Get to know good websites you can refer people to if they want to find out more about their wellbeing. Health Navigator and Kid-Health are designed for New Zealanders and all information is clinically checked.

Push back when you hear colleagues talk about people having low health literacy. Explain that our health and services are complex, and when people face new health literacy demands, particularly when they are stressed and unwell, it is the role of healthcare staff to identify and meet their needs.

Be kind to yourself and find the joy in understanding people and the communities you work with, so you might better help them grow their understanding of health and improve inequities in health outcomes.

Kia kaha

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