Physiotherapy practice is changing rapidly, with greater leadership opportunities and recognition of physiotherapy across healthcare sectors. For example, physiotherapists increasingly hold leadership roles in management of chronic disease and other inter-professional teams, engage in extended scope of practice duties, perform triage roles in tertiary centre clinics and emergency departments, have the opportunity to progress to clinical specialisation, and lead prestigious research programs. Such professional advances bring greater responsibilities in providing health information. Indeed, continued recognition as important and highly skilled health professionals demands that we deliver reliable and accurate health information to our patients and stakeholders so that they can make informed decisions about their healthcare.

Critical elements of a patient-centred healthcare approach

Effective information exchange is particularly important in physiotherapy practice since this constitutes a fundamental component of most patient-practitioner encounters (Liddle et al 2009), particularly in the context of self-management. In order to do this effectively, we must consider how this information is made available and the manner in which it is delivered, and ultimately understood. As the requirement for self-management in healthcare is increasingly emphasised, especially in the management of chronic conditions, patients are asked to assume greater responsibility in:

- handling diverse information resources such as educational materials, prescriptions and medical forms;
- navigating different healthcare settings;
- communicating with a range of health professionals who will have different experiences and approaches in how they deliver therapeutic instructions or advice; and
- making informed decisions about their healthcare including adhering to prescribed therapeutic regimens and implementing lifestyle changes to optimise health.

To undertake these tasks effectively, patients require a basic set of skills which enable them to seek, understand, and utilise health information, a concept referred to as health literacy (USA Department of Health and Human Services 2000). This editorial outlines the importance and relevance of health literacy to physiotherapy practice and potential ways to optimise the exchange of information during the physiotherapist-patient encounter.

What is health literacy?

Myriad definitions of health literacy exist, leading to debate as to what health literacy represents and how it should be measured. However, across definitions there is a consistent theme that patients require a distinct set of abilities to seek, understand, and use health information. Some definitions focus on literacy and numeracy skills, while others encompass broader attributes such as conceptual and cultural knowledge, and social skills. Increasingly, health literacy is recognised as a complex multidimensional concept that involves interaction between patient abilities and broader social, environmental, and healthcare factors (Jordan 2010a).

Why is health literacy important in healthcare?

Low health literacy has been linked to poor health behaviours and outcomes, independent of other socio-demographic factors (DeWalt et al 2004). It is therefore recognised as an important public health issue both in Australia and internationally. For example, a recent report concluded that low health literacy skills increased national annual healthcare expenditures by $US73 billion (USA National Academy on an Aging Society 1999).

Several reviews have highlighted the relationship between low health literacy and poorer health behaviours and outcomes (Box 1) (DeWalt et al 2004, Paasche-Orlow et al 2005). Baker et al (1998) examined the association between low health literacy and the likelihood of admission to hospital in a prospective cohort study of patients presenting to an urban emergency department. Patients with low health literacy were more likely than patients with adequate health literacy to be hospitalised. Low health literacy has also been associated with less utilisation of preventive healthcare services. For example, in a study of people aged 65 years and older, those with low health literacy were more likely to report never having received an influenza or pneumococcal vaccination (Scott et al 2002). Low health literacy has also been associated with poor adherence to prescribed medication (Chew et al 2004) and poorer chronic condition self-management skills (Schillinger et al 2002). In a hospital-based study of patients with type 2 diabetes, those with low health literacy were twice as likely to have poor glycosylated haemoglobin (HbA1c) control, after adjusting for potential confounders (Schillinger et al 2002).

Box 1. Health behaviours and outcomes associated with suboptimal health literacy.

- Reduced health-related knowledge
- Poor self-management skills
- Poor communication between healthcare professionals and patients
- Non-adherence to medication
- Lower self-reported health status
- Reduced use of preventive healthcare services
- Increased risk of hospitalisation
- Increased healthcare costs

Collectively, these studies indicate that health information is a critical factor in shaping individual health behaviours and
outcomes; they provide strong evidence that the inability to seek, understand, and use health information directly influences an individual’s health management. They also highlight the importance of the role health professionals play in ensuring effective delivery and uptake of information, particularly when the information is directed towards a patient-centred management approach to a long-term health condition. For example, in a recent study examining health literacy among patients with chronic low back pain, we identified that although physiotherapists were considered to be principal providers and ‘specialists’ in information related to low back pain, their use of biomedical terminology and limited range of methods used to deliver information were identified as key barriers to patients’ understanding (Briggs et al 2010). Other studies also highlight that patients’ understanding of biomedical terminology is limited (Lerner et al 2000), especially with respect to anatomic terms (Weinman et al 2009), which clearly has implications for physiotherapy practice. Further, we identified that barriers to patients utilising back pain information provided by clinicians included competing lifestyle commitments, socioeconomic circumstances, and prescribed treatment not being consistent with their attitudes or beliefs. These barriers to understanding and utilising health information represent important considerations for physiotherapists in clinical practice who anticipate that patients will both understand and utilise information provided.

**Are clinicians health literate?**

Given the increasing relevance of health literacy to primary care practice and patient health behaviours and outcomes, it may be timely for health practitioners to consider (i) their own health literacy, particularly in the context of evidence-based care and utilisation of clinical guidelines, and (ii) ways to optimise their ability to assist patients to understand and utilise health information.

Recent evidence suggests that many practitioners fail to apply evidence-based care consistently or to utilise clinical guidelines. This has been demonstrated recently in the context of low back pain (Williams et al 2010) and reinforced by surveys highlighting that many clinicians still rely on a biomedical model of low back pain aetiology and advocate activity avoidance (Bishop et al 2008), discordant with current evidence-based guidelines. This issue highlights potential barriers encountered by clinicians in seeking, understanding, and utilising health information in clinical practice, specifically best evidence and guidelines. Indeed, barriers to the implementation and uptake of clinical guidelines remain a research priority in health. In addition to the use of clinical guidelines to inform practice, provision of accurate and appropriate information to health consumers is a critical element in shaping a patient’s health behaviour and attitudes. There is evidence that practitioner beliefs about low back pain influence patient beliefs (Linton et al 2002), and therefore the understanding and utilisation of health information. In a recent study, patients with chronic low back pain and high disability tended to cite pathoanatomic reasons for their pain more consistently than those with chronic low back pain and low disability (Briggs et al 2010). This raises the question, are patients receiving the correct information about chronic low back pain aetiology from their health professionals?

In addition to providing accurate and evidence-based information, it is also imperative that health professionals ensure patients understand and utilise the relevant information being delivered to them. An individual’s ability to seek, understand, and utilise health information is greatly influenced by broad social, environmental and healthcare factors (Briggs et al 2010, Jordan 2010a). Although clinicians definitely play an important role in enhancing a patient’s health literacy, they need to realise and accept the part played by these other factors in modifying the outcome, and work within these constraints. Evidence about interventions to improve the health behaviours and outcomes of patients with suboptimal health literacy is slowly emerging (DeWalt 2007). To date there have been three main approaches:

1. Improving the readability and comprehension of written health materials.
2. Utilising multi-media forms or different techniques to enhance patient-health professional communication.
3. Training and education of health professionals to assist them to effectively manage individuals with suboptimal health literacy.

Notably, these approaches are consistent with recommendations in the Models of Care developed for various health conditions in Western Australia (http://www.healthnetworks.health.wa.gov.au/modelsofcare/). Clinical studies evaluating different training and communication strategies demonstrate promising results – increasing health professionals’ awareness and ability to enhance patient health literacy. For example, a communication method shown to be highly effective is the ‘teach back’ method. This involves the health professional, after initially providing verbal information, asking the patient to reiterate the information in their own words. This strategy provides an opportunity to clarify understanding and confirm recall of the patient (DeWalt 2007). A study conducted in a diabetes clinic reported that when the ‘teach back’ strategy was used in consultations, patients were eight times more likely to have better controlled HbA1c levels compared to patients whose health professional had not used the strategy (Schillinger et al 2003). Health communication training has also been shown to be effective in managing patients with low health literacy. In a randomised trial of health communication training delivered to general practitioners (GPs), those patients under the care of GPs in the intervention group were more likely to undergo colorectal cancer screening than patients treated by GPs who had not received the training (Ferreira 2005).

Whilst training and education strategies exist, it is important that health professionals are provided with adequate resources and opportunities to assist patients with suboptimal health literacy. It is an area that will need to be explored further by policy makers and healthcare organisations, particularly given current national health initiatives (see below). Another consideration may be to implement health literacy screening within clinical settings to identify patients with inadequate abilities to seek, understand, and utilise health information. Whilst a range of health literacy measurement tools exist (see Jordan et al 2010b), they predominantly measure reading comprehension abilities, which do not represent the breadth of components implied in existing definitions of health literacy. Further empirical evidence demonstrating the validity and reliability of existing measures is also required before considering feasibility at a clinical level (Jordan 2010b).
Conclusion

Not surprisingly, health literacy is starting to be addressed at both health policy and program levels in Australia. Both the Health and Hospitals Reform Commission Report and the National Primary Health Care Strategy outline key initiatives relating to health literacy. These include health professionals supporting patients to improve their health literacy skills to navigate the health system, engage in preventive activities, enhance self-management, and change risky lifestyle behaviours. Similar policy and program initiatives are also in development by state governments. For physiotherapists, who are recognised primary care clinicians and spend considerable time with patients delivering health information, particularly in the context of chronic condition management and post-surgical rehabilitation, these policy initiatives imply that clinicians will increasingly need to be familiar with health literacy concepts, measurement, and interventions to assist patients in seeking, understanding and utilising health information.

References


Erratum

In Vol 55 No 3 there was an error in the results reported in the paper by Stevens et al (2009). The error occurred in the final page make up. The last two paragraphs of Column 1 p. 188 should be corrected as follows (corrected text in bold type):

‘Linear regression analysis was also performed to determine whether total amount of physical activity was predicted by revision hip arthroplasty. The regression coefficient for being in the revision group was −394.3 (95% CI −701.1 to −87.5). The regression coefficient for being in the revision group of −121.2 (95% CI −408.0 to −165.7) was no longer significant when age, gender, and Charnley group were added to the prediction equation, suggesting that these additional predictors did confound the relation between group and total amount of physical activity (Box 2). Revision group, age, gender, and Charnley group accounted for 18% of the variance in total amount of physical activity.

Finally, linear regression analysis was performed to determine whether total intensity of physical activity was predicted by revision hip arthroplasty. The regression coefficient for being in the revision group was −1153.7 (95% CI −2241.1 to −66.3). The regression coefficient for being in the revision group of −912.8 (95% CI −1989.1 to 163.6) was no longer significant when age, gender, and Charnley group were added to the prediction equation, suggesting that these additional predictors did confound the relation between group and total intensity of physical activity (Box 3). Revision group, age, gender, and Charnley group accounted for 9% of the variance in total intensity of physical activity.’

AJP apologises to the authors and to our readers.

Reference