Ruth Armstrong reported on the Centre for Primary Health Care and Equity (CPHCE)s’ Annual Forum, held in Sydney on 19 September, 2018, for the Croakey Conference News Service.

Croakey is a social journalism project for public health based in Australia. [http://croakey.org](http://croakey.org)
Contents

#CPHCE Forum preview: navigating our way to equity in the health system and beyond ................................................................. 3

How early life experiences shaped a stellar career in public health: Professor Don Nutbeam ........................................................................ 8

Making health literacy everyone’s business – #CPHCE forum profiles innovation and empowerment in communities.................................................. 17
#CPHCE Forum preview: navigating our way to equity in the health system and beyond

How can the health system help to build community literacy? How might this affect people's capacity to act on information needed to make public health decisions – including on the big issues, such as climate change, globalisation and economic policy?

And how might improving the health literacy of organisations and systems help to tackle health inequities?

These and other big-picture questions are on the agenda of a forum hosted by the Centre for Primary Health Care and Equity (CPHCE) at the University of NSW.

Ruth Armstrong writes:

A recent news item on SBS television showed an initiative based on the NSW South Coast, in which a group of adults whose first language was not English toured a hospital and received basic education about how and where to access care when they needed it.

The participants interviewed mentioned language as their main barrier to navigating their health needs – understandably given the group’s background – but the reporter made a startling and more general claim: that “sixty percent of Australians have a poor understanding of what to do when they get sick, and where to go to get better (sic).”
The figure comes from the 2006 ABS *Adult Literacy and Life Skills Survey (ALLS)*, which reported a subsection on **health literacy**.

The ABS found that 59 percent of adult Australians overall (75 percent of those born in a non-English-speaking country) did not have adequate health literacy, defined in this survey as “the minimum knowledge and skills required to understand and use information relating to health issues such as drugs and alcohol, disease prevention and treatment, safety and accident prevention, first aid, emergencies, and staying healthy.”

### An equity issue

Definitions of health literacy **vary**, as do estimates of the proportion of the Australian population with low levels.

A widely accepted definition from WHO is “the cognitive and social skills which determine the motivation and the ability of individuals to gain access to, understand, and use information in ways which promote and maintain good health”.

But however health literacy is defined, an important aspect of the ABS survey is consistently replicated. As well as being much more prevalent in non-native English speakers, low health literacy is associated with lower family and personal educational attainment, older age, non-participation in the workforce, and lower income.

Health literacy is an equity issue.

It’s not surprising, then, that health literacy is the topic that has been chosen a **forum** hosted by the Centre for Primary Health Care and Equity (CPHCE) at the University of NSW, in Sydney.

### The CPHCE and health literacy

The CPHCE **forum** is an annual event, which aims to highlight the work of the CPHCE, and broaden the discussion of a primary care/health equity issue that comes under the Centre’s purview.

“Health literacy is emerging as an important field of research and practice that cuts across several domains of CPHCE’s work,” Executive Director of the Centre, Professor Mark Harris told Croakey.

“It’s vital to primary care, because it is closely related to the health actions that people will take. Everything they do in response to health information is related to health literacy.”

Having low health literacy makes it more difficult to participate in decision-making, comply with treatment, follow best health practices, and access preventative and other health services.

And this plays out in health outcomes.

**International research** has linked poor health literacy with poorer physical and mental health.

Because health literacy tends to be shared in families and social networks, disadvantage can be compounded by other problems that threaten health, such as an inability to afford health care or medicines or to make informed choices about when and how to access services.
The forum

Heading the forum’s program, and providing inspiration for the forum’s discussions is Don Nutbeam, Professor of Public Health at the University of Sydney, who will present the annual Ian Webster “Health for All” Oration.

Having had a distinguished career in public health academia and policy in the UK and Australia, Nutbeam’s research has included interventional studies in schools and communities around the world. His work has tracked the international evolution of thinking and practice in health literacy since the 1990s.

Recent projects have included collaborative research to evaluate how different countries address health literacy via national strategies, and involvement in research projects on the efficacy of digital platforms and telehealth for effectively boosting patients’ understanding of, and response to health information.

The discussion to follow will be chaired by the Director of The CPHCE, Associate Professor Freddy Sitas. Sitas’ background is in cancer epidemiology and control, and one of his many hats includes being a Chief Investigator on the Cancer Lifestyle, Evaluation And Risk Study (CLEAR).

He told Croakey he believes we have a long way to go in Australia in getting our messages through about cancer – from prevention, to causation, to treatment options, to prognosis.

Health care: a not-so-level playing field

According to Professor Mark Harris, the primary aim of the forum is to bring participants together, to share and learn about practical solutions to support health literacy in the health sector.

Harris has uniquely practical form in the game, having worked for many years with people with some of the greatest need for health literacy assistance in the country.

In July 2018 he was awarded Officer of the Order of Australia (AO) in the Queen’s Birthday Honours, for “distinguished service to education, and to the community, in the area of public health care, evidence-based practice, and equity, as an academic and researcher, and to refugees”.

His work with refugees is very hands-on, as a volunteer GP of 18 years standing at Sydney’s Asylum Seekers Centre where many of the patients face uncertain futures with limited English language skills and insecure access to healthcare.

Harris told Croakey that health literacy is one of the domains in which equity does not equate to equality. He said:

“The concept of I treat everyone the same is not helpful. Clinicians need to tailor what they do and say to existing health literacy, plus seek to enhance existing literacy.

But the health system also needs to simplify clinical and organisational complexity, and find effective ways of building community health literacy. Solutions are not individual, but system-wide."
The more vulnerable the group the more important this is – refugees, new migrants, Indigenous people and other groups need special consideration re health literacy.

For example, people with severe mental illness die up to 20 years prematurely from cardiovascular disease. For them, support and brokering are required, and there’s a need to simplify the system.”

Domains of health literacy

Sitas and Harris told Croakey that the discussion points at the forum will be underpinned by three domains of health literacy – clinical (relating to general practice encounters), organisational (from health promotion to health care and everything in between) and community.

The panel members will be:

- Nicola Dunbar, Director of Strategy and Development at the Australian Commission on Safety and Quality in Health Care (In August 2014, Australian, state and territory Health Ministers endorsed the Commission’s National Statement on Health Literacy as Australia’s national approach to addressing health literacy)
- Amy Prince, Director of Planning and Performance at South West Sydney Primary Health Network (increasing community health literacy is a SWS PHN strategic goal)
- Regina Osten, Program manager for primary and chronic care at the NSW Agency for Clinical Innovation, which has produced a consumer enablement guide for healthcare providers (pictured below).
- Don Nutbeam, Professor of Public Health, University of Sydney, and
- Lou-Anne Blunden, Director, Clinical Services Integration, Sydney Local Health District.

Challenging times

The panel members are well placed to examine these issues, but we are in challenging times.

Copious amounts of information about disease prevention and management are available online and elsewhere, but it requires critical skills to evaluate the quality of information and to decide how to use it, for example, to manage obesity.

Health care is also increasingly fragmented with care models are that rapidly evolving and increasingly demanding of individual capabilities. For example, a patient or family may need to plan their care via NDIS, or coordinate services with My Aged Care packages.
Those with low health literacy may miss out on services, but can also be more vulnerable to over-diagnosis and over-treatment.

Harris stressed that system-wide responses are required to improve health literacy which, after all, is not simply related to the patient’s skills and capabilities but is also a product of the demands of increasingly complex healthcare systems. We need to find ways for everyone to get what they need, out of the care available.

“We need navigation to make that happen,” he said. “Navigation support extends to risk factors (prevention) and also to chronic disease management.”

**Community is key**

The third concept: that of building health literacy in the community, is important for two reasons.

Firstly, an expanded, “public health” definition of health literacy includes “the degree to which individuals and groups can obtain, process, understand, evaluate, and act on information needed to make public health decisions that benefit the community” – including on the big issues, such as climate change, globalisation and economic policy.

And according to Harris, community is key to everyone’s health literacy. As he told Croakey:

> “Health literacy resides in the community, not in individuals. An individual’s health literacy depends on all the resources they have to draw on.”

**A wish list**

When asked for a wish list of forum outcomes, Harris and CPHCE colleague, Associate Professor Jane Lloyd, came up with the following:

1. Recognition of the need to be responsive to diverse patients’ needs (language, culture and health literacy) if we are to and provide opportunities for equitable patient engagement.

2. Monitoring of the harms of the disparity between the literacy level of patients and their carers and complexity of information required by health services.

3. Development and evaluation of interventions to address these disparities in health care including those designed to improve communication, decision making and improve navigation to services and programs.

4. Greater action to address low health literacy at an organisational level, including service design and patient engagement to support patients with low health literacy.

* Preparation of this article was assisted by an interview with Associate Professor Freddy Sitas and Professor Mark Harris, and written responses from Professor Mark Harris and Associate Professor Jane Lloyd.*
How early life experiences shaped a stellar career in public health: Professor Don Nutbeam

At the recent annual forum of the Centre for Primary Health Care and Equity (CPHCE) at the University of NSW, public health leader Professor Don Nutbeam shared some personal stories from his early years to make broader points about the complexity of forces shaping health.

His personal history highlights the importance of the social determinants of health and individual health literacy and choices, of role models such as teachers, and of the “utterly transformative” power of education.

Ruth Armstrong writes:

“We are so fundamentally shaped by the social and economic circumstances that we grow up in.”

This statement, from Professor Don Nutbeam's address to the recent annual forum of the UNSW Centre for Primary Health Care Equity (CPHCE), is core to understanding the social determinants of health, but it also holds true for the way we live our lives – what underpins our thinking, drives our passions and motivates our choices.

We bring ourselves to everything we do.
Nutbeam, who is currently a Professor of Public Health at the University of Sydney, was at the forum to deliver the annual Ian Webster Health for All Oration. He has had a stellar career in public health – forty years in health education and health equity including senior university and public sector roles in the UK and Australia – but he confessed to finding the topic chosen for his oration unusually challenging.

Being asked to speak on health education, health promotion, and health literacy – a personal journey, set Nutbeam on (for him) the unusual path of looking backwards, which he usually avoids “so he can’t see who’s chasing,” and of reflecting publicly on his personal life, which he finds uncomfortable.

But the personal touch added an important dimension: Nutbeam’s early life, which he was quick to deem unremarkable, set him up well for some deep and intuitive understandings about what influences health, and what needs to change to improve it.

A personal journey

The youngest of five children, and the son of a Portsmouth dock worker, Nutbeam was born after the second world war, into a family who had been displaced and moved to temporary accommodation in another town, after their home was destroyed in a bomb raid.

His early years were spent in tenement housing on a public estate with outdoor plumbing, no heating and no hot water. He remembers being hungry at times, and cold, but secure and cared for, with no real sense of deprivation.

Nonetheless his “normal environment” was not what we would not consider healthy. Every adult he knew smoked, there was high unemployment and many people were chronically unwell. His own father had to stop work due to chronic lung disease when Nutbeam was about four, and died of the disease when he was fourteen. His mother worked several jobs to support the family.

As the first child from the housing estate to be offered a place at the local selective grammar school, Nutbeam entered an “entirely different world”.

He did well at school but still had no expectation of obtaining a university education, until his ex-headmaster plucked him from a job as a bank clerk, and helped him apply for teacher training college at Southampton, where he subsequently also obtained his higher degrees in health education and epidemiology.

These life experiences, Nutbeam believes, formed the basis for some understandings that have underpinned all his work. He told the forum:

“Intuitively I have always understood that social, economic and environmental conditions shape our lives and our life chances. But I also didn’t need any persuading that there’s something about individual behaviours, personal choice that really matters.”
I understood the connection between the way people live their lives and the social and economic circumstances in which they live. Role models (such as teachers) are really important, and education is utterly transformative.

If we want to change things, one of the most important things we can do is engage with people, whether it be through formal education or health education. The most transformative changes in people’s lives and health, in my experience, have come because people have engaged with their health on the basis of better understanding about it.”

This theme – the need to work both on the social determinants of health and improve health literacy of people, systems and communities wherever they are – recurred throughout the day-long forum.

Lessons from a career in public health

When Nutbeam began working in the British NHS in 1978, he quickly became frustrated by the dominant public health messages of the day, which, under the leadership of a new conservative government, adhered to a narrow individual, behavioural approach.

In a fascinating walk through the people, places and jobs that shaped his career, Nutbeam told us how his first major project tackling smoking in hospitals led to fruitful collaboration with, and much learning from epidemiologist, John Catford, who seconded him to work with him on a region-wide study of smoking in the NHS.

Along with Catford, he began working on a new concept – that of health promotion – to replace the narrow definition of health education, which the two wrote about in a seminal 1984 paper. They put forward that, as well as education, health promotion encompassed environmental and organisational change; economic and regulatory activities; and community development, emphasising the importance of preventive health services.
For about two years leading up to the Ottawa Conference on Health Promotion and the Ottawa Charter, both men worked under the direction of renowned German global health and health policy expert Ilona Kickbusch, who was then in charge of health promotion activities at the WHO.

Nutbeam defines his involvement in the Ottawa Charter as his **Major Project number 1**, and he still loves the simple message it conveys, of “making healthy choices easy choices”.

In hindsight, and not detracting from the importance of the Ottawa charter, Nutbeam believes that one of the effects of the wave of enthusiasm for health promotion that followed its release was an unintended diminution in the importance of health education.
The offer of a Chair in Public Health at the University of Sydney led to Nutbeam’s **Major Project number 2**, working with a “dream team” that reviewed and revised Australia’s National Health Goals and Targets. He considers the resulting document to be a “blueprint” of how to organise public health in a nation.

For better, more equitable health in populations, improved health literacy and healthy environments are interlinked. They determine how people live their lives, and how we reduce avoidable mortality and morbidity.

In another salutary lesson for those working in public health, an election was called within three months of the new strategy’s publication and the new health minister was not interested in it. According to Nutbeam, the plan was “basically binned” but he believes the figure above remains the most effective way to understand how to improve public health.
It was another political event that led to Major project 3 when Tony Blair swept to power in England, and lured Nutbeam back to become head of public health for the UK. This led to a revolutionary whole-of-government program to tackle health inequalities – “health in all policies before health in all policies”.

What has Nutbeam learned from his three major projects? He shared the following key lessons:

- Addressing health inequity is hard, complex and involves sustained action across sectors
- Health promotion strategies offer the most complete response to this entrenched and complex problem
- Focusing only on the social determinants runs the risk of alienating those we seek to benefit if it leads to the practice of doing things to, rather than with them. Improving health literacy provides the foundations for meaningful, empowering engagement in health, and bringing the two together provides a powerful platform for change.

Health literacy: an idea whose time has come

Based on his observations in the 1990s, Nutbeam published a paper in 2000 entitled, Health Literacy as a Public Health Goal: A challenge for contemporary health education and communication strategies into the 21st Century, which classified different forms of health literacy and pointed out that health literacy was linked to empowerment, connecting it to the social determinants of health.

The paper was virtually ignored at the time of publication, but began to be cited in about 2008, and is now his most highly cited paper. Professor Evelyne de Leeuw, the current Editor of Health Promotion International, where the article was published, confirmed from the audience that it has now been downloaded more than 100,000 times.
Australia is not alone in this renewed interest, and in linking health literacy to formal quality and safety standards. Nutbeam says there is a resurgence of interest all around the world.

For his current project, Nutbeam is having the time of his life, working along with the University of Sydney, Western Sydney Primary Health Network-WentWest and Western Sydney Local Health District, on a Health Literacy Hub.

The hub aims to create much more health literate health organisations through various interconnecting strategies (see slides). It is about to launch an interactive self-help portal that gives people immediate access to resources and support tools to help them improve interpersonal and written communication.

They currently have 400 people signed up to their community of practice, and staff will be seconded from different parts of the LHD to come and work in the hub, then return to their day jobs as “health literacy ambassadors”. They have developed several priority areas for their work, and research in association with the University of Sydney Health Literacy Lab.
Poor communication: a costly mistake

If Nutbeam’s experience in Western Sydney is anything to go by, we will soon be seeing a groundswell in health literacy initiatives in our hospitals, surgeries and health and community services.

As part of the panel at the CPHCE forum, he spoke about the high and ongoing cost to not getting communication right:

“We already invest an awful lot in our health care system in poor quality communication. Every interaction that occurs between a health professional and a patient is an investment of time, and we’re paying for that time.”

“There are hundreds, if not thousands, of poor quality written materials, poorly constructed letters, poorly constructed appointment systems. We’re already massively invested in poor communication, and getting it right can both deliver improved patient outcomes and save the healthcare system cost.”

This advice was enough to convince the financial decision makers in the Western Sydney health district to invest in projects to improve health literacy in health systems and services, he said, “and we were talking about a systems response – a change in the quality of communication within the system – not about improved health literacy within individuals and communities.”
See the interview with Don Nutbeam
Making health literacy everyone’s business – #CPHCE forum profiles innovation and empowerment in communities

Ruth Armstrong writes:

Health literacy has been seen as a two-way street, comprising an individual’s skills and resources on one side, and the complexity and navigability of the information and systems they are trying to traverse on the other.

But looking closely, it’s really or more like a complex intersection of all the things that feed into these categories on both sides – the social determinants of health, community and other resources, language, culture, system reflexivity, communication skills, cultural safety and more.

So where and when to we intervene to improve people’s understanding about health, their ability to navigate health systems and their empowerment to live healthy lives they value?

The answer is at every point of contact, and all the time. With respect, humility, curiosity, creativity, passion, trust and, very often, patience.

This was the big take-away from the recent annual forum of the Centre for Primary Health Care and Equity (CPHCE) at the University of NSW, where participants heard about diverse, on-the-ground projects empowering communities in south western Sydney.
Health literacy is core to the CHPCE’s work. The Centre works closely with its research partners, on projects to improve health literacy in primary care, in health organisations systems and services, and in communities with high needs.

Three short presentations from the three collaborative research hubs of the CPHCE looked at the Centre’s health literacy research projects, providing fodder for the forum’s discussions.

Tools for prevention in primary care

Professor Mark Harris, Executive Director of the CPHCE, said low health literacy is common in primary health care and is associated with increased risk.

Although there are very good measures of health literacy (such as Australia’s Ophelia), finding an accurate screen to use in practice has proved challenging.

The question “How confident are you filling out medical forms by yourself?”, originally devised by Dr Lisa Chew and colleagues, is probably the best discriminator currently available for use in practice.
The CPHCE has been collaborating on trials using practice nurses trained to support health literacy using the “5As” (Ask, Advise, Assess, Assist, and Arrange).

These include advice using communication techniques such as Teachback, goal setting, referral to telephone coaching or face to face group program and follow up, as part of the Better Management of Weight in General Practice study, with promising improvements in health literacy at 6-month follow-up.

Harris also mentioned the IMPACT study in south west Sydney, which involves practice nurses using the above techniques, as well as supporting access to online health information for patients with Type 2 diabetes, in both Arabic and English. Qualitative feedback collected so far indicates variable ease of use and understanding of the website and educational material.

Building on the work with practice nurses and hot off the press is the Centre’s current collaboration to produce and trial the addition of a purpose-built patient-facing app, my snapp. This is for chronic disease prevention in general practice patients with low health literacy, and is in being tested at the moment.
The app focuses on goal setting and self-monitoring, and referral to the telephone coaching line, *get healthy*.

Harris said efforts to improve health literacy in primary care were an “ongoing journey” but there were some lessons learned along the way. He said:

“We need to focus on reducing the information demands on patients, as well as supporting improvements in their health literacy.

Routine general practice care is usually insufficient to support significant change in health risks. It can be supplemented by information technology as long as it is tailored to patients’ health literacy and language skills, and the tailored information is actively supported by GPs and practice nurses.”

Health literacy, culture and language

Associate Professor Jane Lloyd Director, director of the Health Equity Research and Development Unit (HERDU), raised some challenging issues for health professionals and organisations.

She reminded us that people are not “empty vessels” just waiting for information to be dropped in.
“We’re all part of communities which, by their very nature, are dynamic and changing, resilient and able,” she said. “So I believe action in and with the community provides a really powerful mechanism for improving health literacy.”

Starting her presentation with this slide on the actions required to improve health literacy at various levels, she asked where should we intervene or, more importantly, where do we intervene first?

Lloyd said that, when she went looking, she discovered a wealth of information and research about improving patient health literacy, but very little about organisational health literacy.

She described health literate organisations as those that reduce the health literacy demands placed on patients and said that, if we want to align these demands better with the public’s skills and abilities, it will require system-level changes.

Lloyd talked about the related (but not to be conflated) concepts of culturally competent communication (understanding that individuals’ concept of health may differ, affecting the way they receive, process and accept information) and linguistic competence (making sure patients who don’t speak English are offered bilingual clinicians or interpreters).

But she also stressed the need for a third quality – cultural humility – which she said is required both on an individual and an organisational level.

Cultural humility turns the lens around, so that health care providers commit to continuously evaluating and critiquing themselves, to redressing the power imbalances between practitioners and their patients, and to forming non-paternalistic and truly mutual partnerships with individuals, communities and populations.

Lloyd said “there’s a lot of culture going on” when we’re at work – including our personal culture, values and beliefs, our different cultures as health professionals and organisational cultures, both aspirational and lived.

She outlined some pathways to professional and organisational responsiveness through health literacy, cultural humility and language resources, and encouraged us to “check our biases”.
Making health organisations more literate

Lloyd described a pilot study, which looked at how Sydney’s Canterbury Hospital was performing in terms of its response to the health literacy, cultural humility and language requirements of its patients.

Employing bilingual educators to tour the hospital with people from the Rohingyan, Bengali and Arabic language groups while conducting “walking interviews”, they found that the in-hospital systems were mostly viewed positively. People felt welcomed.

A surprise finding, however, was that patients found it more difficult to get to the hospital than to navigate their way around the campus. They realised that hospital tours actually needed to start at a known point (in this case the library) so that the patient and educator could travel to the hospital on public transport together.

The Rohingya Little Local

Lloyd presented an example of a population-based intervention, occurring through Can Get Health in Canterbury (CGHIC). This partnership, between Sydney Local Health District, Central and Eastern Sydney PHN and the CPHCE, aims to improve health and reduce inequities for marginalised culturally and linguistically diverse populations in the area.

One of CGHIC’s projects is within the Rohingyan community, about 800 of whose members live in Canterbury. It is based on the concept of The Big Local in the UK, where a lottery-funded initiative saw resident-led collectives in 150 areas receive a million pounds each over 10 years, to decide on and fund initiatives to improve health.
Funding for CGHIC’s “Rohingya Little Local” is more modest – a one-off allocation of $10,000 – and comes on the back of several years of conversations and activities with the Rohingya community.

The team has handed the decision-making about how to spend the money to the community. As they develop their own priorities, it is hoped the community members will hone their skills in negotiation, decision-making, and actions to improve health.

It hasn’t always been comfortable or easy, said Lloyd. The team has had questions about issues such as how to define the community, who to include, the role of women and how much support to provide.

“We will see where it takes us,” she said.
Building community health literacy

The Centre for Health Equity Training, Research and Evaluation (CHETRE) has, as one of its three “streams”, a Locational Disadvantage Program, which involves engaging with residents and groups in communities in south western Sydney that suffer health and other disadvantages.

Dr Siggi Zapart, a senior research and evaluation Officer for CHETRE’s locational disadvantage stream, and Andrew Reid, a community development research officer, presented an impressive tag-team round-up of some of the stream’s activities.

Reid said Community STaR (Service for training and research) focuses on increased community engagement, participation and empowerment, through education and training to support the development of community events and programs that reflect issues of community concern and interest.

Some Community StaR programs and activities include:

- Learning circles (focused discussions in which residents talk about issues and how to address them).
- The provision of training to provide skill development and job experience
- Community forums, and seminar and speaker program, based around local and locally identified, wider, issues, with Australian and international speakers
- Working with partners to identify perspectives, needs and issues, and to support community-led programs and campaigns.
In the past few years, in partnership with other organisations, Community STaR has run forums on a range of issues including preventing alcohol-related harm (with a focus on local issues and a follow-up forum to monitor progress), men’s health (looking at overcoming barriers to engagement), family drug support services and how to access them (for frontline workers), dual diagnosis (for frontline workers), climate change, social inclusion, food (looking at food advertising and food security), community gardens, and environmental issues.

In 2016, CHETRE partnered with Liverpool Council and others to produce a film “Residents verdict: not Dodge City,” in which residents shared their feelings, experiences, ideas and aims for the future.

Reid also described CHETRE’s Working in Locationally Disadvantaged Communities (WiLDC) course, which supports workers in health and non health organisations to learn about the causes and consequences of locational disadvantage, and conduct community projects aimed at improving health.

Participants attend workshops, undergo site visits and excursions to other established community programs, and receive help desk support.

Participants have gone on to run community programs aimed at cultural and age appropriate healthy lifestyle initiatives, chronic disease management, vaccination, and men’s and women’s health, in areas of Sydney such as Fairfield, Bankstown and Liverpool (see slide).

CHETRE’s future plans for their Locational Disadvantage Program, Siggi Zapart told the forum, include first aid training for residents and workers, developing a Local Drug Action Team action plan, a forum on gambling related harm, several new workshops, and a “scaled out and restructured” WiLDC course.
They are also looking at new partnerships to enhance community connectivity through art, green space and neighbourhood participation, a sport-based men’s health project, family mentoring and group-based support for newly arrived migrants and refugees, and creating a skilled and sustainable network of community health champions.

Zapart said three things underpinned the work of improving health literacy in locationally disadvantaged communities: raising awareness of the social determinants of health; capacity building; and enabling, supporting and encouraging community action.

She said the work could be replicated in other communities: “These actions lead to empowered community members who are motivated to take control of their lives and to take actions that will improve their wellbeing.”

From the standards to the coalface

Reflecting on the day’s discussions, Nicola Dunbar, Director of Strategy and Development at the Australian Commission on Safety and Quality in Health Care, said the Commission had been working on strategies to improve health literacy since about 2012, when they noticed the topic was being raised “organically” as a determinant of safe and high quality care.

The focus had been on individual health system users, but the Commission began to think about what could be done from a health system/health services perspective.

“What changed it for us was work that came out of the Institute of Medicine on health literate organisations… We asked ourselves, How can we help health services to make it easier for people – to reduce the information load?”

The Commission went on integrate some things we know are effective on the “supply side” of health literacy – such as communication, partnerships and way-finding – into the safety and quality standards.

“If it’s in the standards, they will pay attention and changes will happen. It’s about identifying those levers, so that they’ll become part of daily practice,” said Dunbar.

“Today has highlighted the varying angles we need to take.”
Lou-Anne Blunden, Director of Clinical Services Integration Sydney Local Health District, said the forum discussions had been a reminder that health literacy has impacts “across the board” – from facilities, to community, to staff, to research and more.

She said her LHD had been working with place-based-initiatives in areas such as Redfern, Waterloo and Lakemba, across agencies – government, NGOs and the community. She said:

“Community is telling us what their needs are. It’s not up to us coming with our solutions; we are learning from them.

It becomes more sustainable once the community starts to take the lead.”

Amy Prince, Director of Planning and Performance at South West Sydney Primary Health Network, said that observing the vast array of work in this area, it’s clear that addressing health literacy is a puzzle.

The GP alone can’t address health literacy but they can sometimes underestimate the power that they have to “just shift the needle a little bit”.

Said Prince: “If every player in the health system takes a strengths-based approach to identify the small changes we can make to improve health literacy, we could really make a difference.”

See the interview with Amy Prince

Momentum building

Regina Osten, program manager for primary and chronic care at the NSW Agency for Clinical Innovation (ACI), picked up on the “strong sense of momentum” from all those involved in health, to improve health literacy.

She agreed that incorporating health literacy into the national safety and quality standards had directed attention to the area “in a way that nothing else we do in the system does”.

You can track Croakey’s coverage of the conference here.
She said the standards were a far more powerful lever than policies in directing accreditation and action within the health districts and elsewhere.

The ACI has been in the process of developing a web resource in consumer enablement, which picks up on health literacy as well as a number of other things related to self management.

When the guide was put out for consultation, Osten said the ACI received “enormously engaged and positive feedback”.

“We might finally get some traction on real person-centred care,” she said.

Professor Don Nutbeam (profiled in this previous report from the forum), reiterated that there is a huge cost to not getting communication at every level of health right. Diverting the money wasted every time we get it wrong will save money and improve health.

More take-homes

There were some other great take-homes for the day, one originating from Denmark, conveyed by the CPHCE’s Professor Evelyne de Leeuw, who reflected on the Danish saying ting tager tid (things take time – the three Ts). It was true, she said, in respect to everything we do:

“**It takes time to read; to sit down with people and share information; to organise things; for ideas to percolate. Maybe we just need to take the time get things right.**”

This was an idea that seemed to resonate for many in the audience.

Exhaustion with constant change was seen as a problem. For local health districts, said Lou-Anne Blunden, there was the constant challenge of developing partnerships with government and other agencies, then a loss of momentum when the other agencies restructure with new leadership and priorities.

She said it helps to have leaders who realise it is a long game with vulnerable populations and that intergenerational impact is required. We need long term plans that don’t change when the leaders change.

Some of the biggest barriers to acting on health literacy were seen as clearly identifying specific problems within a system to be solved, specific actions to take, and robust ways of measuring outcomes.
On the topic of how we identify targets and measure change, Professor Don Nutbeam was sanguine. He told the forum to be on the lookout for practical responses to common problems, and not to get too hung up on definitions.

He advised: “Try to identify a couple of points within the system or in your local area, where we think improved communication can really make a difference to patient quality and safety, and can make an observable change, and make it happen.”

And an interesting, final comment from the floor was that, on one level, this comes down to trust – not just the trust that patients and community members place in those who are helping them to improve their health, but trust in ourselves.

The forum participant said: “We’ve known for a long time that better informed people make better decisions, but somewhere along the line we lost trust that better communication would improve outcomes for our patients. We need to rebuild that trust.”

In the final analysis, Professor Mark Harris reminded us as he closed the day, health and health care is mostly about information – and that accessing, understanding and using that information is becoming more complex.

Individuals, health services and researchers need to work towards improving all aspects of health literacy, while realising it is a long game.
Prizes

The forum concluded with the CHPCE’s annual awards, which were in three categories: partnership awards, career achievement awards and general practice research awards.

Some of the recipients are pictured in the tweets below, and Croakey spoke to one of the GP research award recipients, Dr Olataga-Alofivae Doorbina, whose enthusiasm for conducting research as a way to improve clinical practice and patient outcomes is an inspiration.

Watch the interview with Olataga-Alofivae Doorbina

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You can track Croakey's coverage of the conference [here](#).
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Making health literacy everyone's business – #CPHCE forum profiles innovation and empowerment in communities

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More tweet reports

Ruth Armstrong @DrRuthAtLarge · Sep 18
@mfharris3 How the #CPHCE contributes to stronger Primary health care

What are we doing to contribute to stronger primary health care?

- New roles for Practice Nurses and Community Health Workers
- Improve implementation of preventive care including management of overweight and obesity in children and adults
- Shared and integrated information system
- Innovative use of m- and e-health in preventive care

Ruth Armstrong @DrRuthAtLarge · Sep 18
@mfharris3 describes how #CPHCE works with local health districts & practices on research & clinical projects

Research Platforms

- Central and Eastern Sydney Cohort (of 45 and Up study)
- CAN-Get-Health in Canterbury
- Health Impact Assessment Unit
- Electronic Practice-Based Research Network
- Urban Health Observatory
You can track Croakey's coverage of the conference here.

Making health literacy everyone's business – #CPHCE forum profiles innovation and empowerment in communities

Rachael Havrlant @RachaelHavr - Sep 16
Interesting new research programs for @cphoe_unsw to contribute to stronger primary care and fairer health care #CPHCE – at John Nilland Scientia Building, UNSW

New research programs
- Community Health Workers as Health Navigators
- Preventive and physical care for patients with Severe Mental Illness
- Health care for socially isolated patients
- Organisational health literacy
- Healthy Airports
- Aboriginal health data governance

Russell McGowan @lazarussell - Sep 18
Tribute paid by Mark Harris to Terry Findlay who embodied the spirit and vision of @cphoe_unsw during his life until his untimely death in December 2017 #cphce

Ruth Armstrong @DrRuthAllarge - Sep 18
Recess in #CPHCE for Bollywood style dance presentation. Very refreshing!
Twitter analytics

Warm thanks to all those who helped to share the #CPHCE news. Twitter analytics for the period of Croakey’s coverage of the forum (16 September-2 October) show there were more than 2.6 million Twitter impressions, with 62 participants using the hashtag. The Twitter transcript can be read here.

Croakey Conference News Service

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