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Framing health literacy: A comparative analysis of national action plans

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ABSTRACT

Population and individual deficits in health literacy, and their associated negative health outcomes, have received growing attention in the political arena in recent years. In order to respond to the problem, several governments have adopted national action plans, which outline strategies to improve health literacy. Drawing on the action plans of the USA, Australia, Scotland, and Wales and applying Entman's concept of framing, this paper analyses how health literacy debates are framed within the political arena as well as the factors that influence framing. Analysing data from policy documents and in-depth expert interviews, this paper identifies relevant frames developed to (i) define the problem of limited health literacy, (ii) provide causal explanations, (iii) rationalise why health literacy requires political action, and (iv) present solutions. The findings indicate that the malleability of the concept allows that a diversity of frames and solutions are promoted, yet risks that debates remain vague. Health literacy seems to have been successfully used to instigate political debates about health system reforms, patient empowerment, and shared decision making. The analysis suggests that health literacy might, if applied strategically, help to focus policy debates on key public health problems and the development of systemic solutions.

1. Introduction

1.1. Health literacy: a public health policy issue

Health literacy, defined as an individual's capability to access, understand, evaluate, and use health information in order to make decisions about health [1–3], has become a highly debated policy issue [4–7] and received increasing recognition as an important public health goal [8–10]. Public policy calls to improve health literacy are based on the notion that those with high levels of health literacy are better able to make judgments and take decisions that help to maintain or improve their health and quality of life, and navigate the health system in case of illness [1,11]. The World Health Organization (WHO) and the Institute of Medicine (IOM) have specifically contributed to raising awareness of the political relevance of the issue via several dedicated publications and workshops as well as explicit calls to address the problem of limited health literacy [12–14]. The WHO, for example, published a report in 2013 titled "Health Literacy: The Solid Facts", which identifies effective ways to strengthen health literacy in a variety of settings [13], and the 2016 Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development which stresses the importance of health literacy for reducing health inequalities [15]. While policy debates on health literacy first became prominent in English speaking countries like the US, Canada, and Australia [16,17], by now, they have spread across most of Europe [16,18–20]. Policy debates in Europe are fueled by international developments as well as by a benchmark based on a survey which measured health literacy in eight European Union member states [19,21].

Currently, it seems to be uncontested that political action can play a crucial role in addressing health literacy and implementing sustainable health literacy initiatives [10,22,23]. Several European governments are currently considering the development and implementation of national strategies in order to improve the health literacy of their citizens [24–26]. Action plans, i.e. documents outlining a comprehensive national or regional strategy which include recommendations, seem to be a popular way of promoting health literacy at the political level.

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1.2. Framing: a political strategy

Political scientists postulate that in today's societies, policies are influenced by advocates' efforts to 'frame' debates, i.e. to develop or apply a set of concepts on how people perceive, and communicate about, reality. In a seminal 1993 article, political scientist Entman [27] critically reviews the concept of framing, elaborates on its potential impact, and postulates that framing is "to select some aspects of a perceived reality and make them more salient [. . .], in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation for the item described". Successful framing thus involves four main aspects:

(i) defining the problem in a way that highlights the features that are most helpful in focusing attention on a specific aspect of the problem;
(ii) providing causal interpretations and rationales that underpin the respective problem definition;
(iii) evaluating the issue in a way that refers to values, conventions and norms, thereby attaching a moral value to the discussion; and
(iv) presenting a preferred solution as an adequate response to the defined problem.

Entman's four aspects of framing relate to how power and privilege influence the political agenda on broad societal topics like immigration or abortion [27]. Skilled advocates use framing as a strategic means of influencing policy debates. By highlighting certain features of a particular issue and encouraging others to think about the issue along particular lines [28], they steer discussions into a direction that makes their preferred policy outcome more likely. Successful framing has shown to affect the attitudes and behaviours of target audiences, and has been used as a powerful tool in setting political agendas, shaping the content and format of policies, and persuading policymakers and the public of the need to adopt certain positions [29]. By setting the tone and contributing to the perception of a problem and its potential solutions, successful framing can have a broad impact on public and political debates and on the transfer of policies across contexts [28,30].

1.3. Framing health literacy: an opportunity to influence political debates

The framing of health literacy debates has not been the subject of research yet, despite the rising prominence of health literacy and the fact that the subject uniquely lends itself to analysing framing in contemporary public health debates. This paper is the first to analyse how health literacy is framed in contemporary policy debates. Using four national action plans as case studies, the analysis employs the four main aspects of framing developed by Entman [27] as a conceptual basis. By critically comparing health literacy debates in four legislatures, the article contributes to a better understanding of recent debates on the topic, provides unique insights into the framing of a contemporary public health policy issue, and develops recommendations that can inform future strategies to improve health literacy.

2. Material and methods

A mixed method study using a two-pronged approach was applied to analyse the framing of health literacy:

(i) A systematic review of policy papers focused on health literacy was conducted in order to identify national action plans aimed at promoting health literacy and compare the framing of health literacy in the respective national context.
(ii) Semi-structured interviews were conducted with key stakeholders who were instrumental in developing and implementing the national action plans to gain an in-depth insight into the policy debates.

The study was conducted as part of a project aimed at developing a national action plan for Germany (for details on the project, please see the acknowledgements).

2.1. Policy documents of relevance to health literacy

Five online databases (PubMed, Web of Science, Fachinformationssystem Bildung, Google, Google Scholar) were searched. Search terms included "health literacy "AND "action*" OR "action plan*" OR "polic*" OR "program*" OR "strateg*" OR "campaign*" OR "initiative*". The corresponding German search terms were also applied. The searches generated more than 3000 hits, among these 57 policy documents (e.g. national, regional and local strategy papers, outlines of national, regional and local policies, scoping reviews, briefings, concept papers, legislative documents, national, regional and local action plans) and three systematic reviews of initiatives to improve health literacy [16–18].

The searches were complemented as follows:

(i) All policy documents were checked for cross-referencing.
(ii) Websites of organisations that were identified through the documentary search as key organisations with a high profile in health literacy debates [31–33] were searched for additional policy documents.
(iii) A consultation was conducted via E-Mail requesting 15 health literacy experts from 10 different countries to send documents related to health literacy policy. The health literacy experts were identified based on their membership in the International Union for Health Promotion and Health Educations's Global Working Group on Health Literacy.

The additional searches and requests generated an additional 23 policy documents. After duplicates were deleted, 61 documents remained for further analysis. In order to select national action plans, the following inclusion criteria were applied:

(i) Published between January 1990 and May 2016.
(ii) Published in, or translated into, English or German.
(iii) Focused on the national context.
(iv) Written, published, or commissioned by a governmental body.

The 2010 US [38], 2010 Welsh [36], 2014 Scottish [37], and 2014 Australian [39] action plans were the only documents that fulfilled these criteria and were thus selected for analysis.

For each selected action plan, a thorough web-based search was undertaken in order to identify additional documents related to the political process and the development and implementation of the plan. All documents identified – including research reports, minutes of meetings, briefings, policy drafts and other documents – were read thoroughly, ordered chronologically and analysed thematically. Key themes, events, organisations, individuals and other important information were extracted and recorded in order to gain an overview of the chronology of events and the key individuals involved.

2.2. Interviews

Based on the thematic analysis of the documentary data and mirroring the research questions, an interview topic guide was

developed, which for each case, covered the following issues: the development of the action plans, the content of the action plan, the evidence base for developing the action plan, and an assessment of the action plan and its impact from the interviewees' perspective. One to three individuals from each country who, according to the documentary analysis had played crucial roles in the development and/or implementation of the national action plans, were selected for interview. All interviewees were recruited via e-mail, with none of the contacted individuals declining to be interviewed. Face-to-face or telephone interviews were conducted with one partner in the US, one in Australia, two in Wales and three in Scotland. The interviews were transcribed and thematically analysed using Nvivo 11.

2.3. Thematic analysis

A content analysis of both the documentary and interview data was performed according to Mayring [11]. Entman's four aspects of framing were used in a heuristic way as an organising framework for analysis of how a specific public health issue (health literacy) was operationalised into policies. In order to do this, coding categories were developed based on Entman's concept of framing. Each of the four dimensions of framing described by Entman were taken as primary codes. Then inductive coding of the data was used to identify prevalent frames within each of the four dimensions, i.e. frames that helped to define the problem, frames to provide causal interpretations, frames to evaluate the problem from a moral perspective and frames to present a preferred solution. These frames were used to develop sub-codes. Subsequently, the sub-codes and frames were systematically compared across the country settings.

2.4. Triangulation of documents and interviews

The documentary and the interview data were treated as equally valid data sources. While the policy documents were used as base for identifying the arguments for the foundation and architecture of the four aspects of framing, the interview data were used to exemplify, illustrate or juxtapose the results from the documentary analysis. Often, the interview data provided valuable background information on the development of the plans and the discussions which had influenced the contents and structure of the documents. They thus helped to identify the rationales that had led to the decision to employ a specific frame.

3. Results

3.1. Common features of the four action plans

All four action plans cover the description of:

- A vision, the aims, and the target audience.
- The problem of limited health literacy and its political and societal relevance.
- The prevalence of limited health literacy and a description of particular risk groups.
- The potential negative consequences of limited health literacy.
- The primary areas of action to improve health literacy.
- The relevant actors needed for the implementation of the plan.

In all four countries, the development of a national action plan was part of broader health policy debates.

As the brief description in Box 1 shows, almost all plans were developed through a two-pronged approach: First, a group of experts discussed the content of the plan, and second, a broader audience was invited to contribute to the debate and development of the plan via a consultation process. All plans stressed the need for a multi-stakeholder process and the inclusion of different sectors. In Scotland, a "National Health Literacy Action Group" helped to drive the process and served as a multiplier across different sectors. In the US, Australia, and Wales, working groups were established within the organisations responsible for developing the plans in order to take the positions of different sectors into consideration. Involvement of citizens and the general public in the development of the plans was primarily evident in the US and Wales.

Governmental support, political will and the passion, motivation, and support of individual political champions were seen as crucial for increasing attention for the topic, making clear that health literacy was a priority, and legitimising the plans. Some statements from the interviews can usefully illustrate these interactions. One Scottish interviewee, for example, highlighted that the support and leadership by the Scottish Government

> "was important in terms of it being promoted and to take it forward as a, kind of, official thing. That would add weight. . .across the NHS. You know, there are so many policies. . .So someone has to say that this is important and that this is a priority."

Often, political support seemed to emerge due to the topic being perceived as a good fit with an existing department's or agency's focus of work. As an Australian policymaker recalled, the ACSQHC had developed an interest in health literacy because it had perceived the US Academy of Medicine's report and its focus on health literate organisations (as opposed to individual health literacy) as particularly relevant to the ACSQHC's work remit:

> "Earlier, when all definitions were framed around the individual, it was hard to see how an organisation dealing with organisational structures [the ACSQHC] might be able to deal with it. But when it broadened out to the organisational side of things, it made it easier to see how it might fit."

As this and other data illustrate, the broad nature and malleability of the concept of health literacy seemed to be an important factor in attracting various stakeholders' attention and facilitating their engagement in the policy debates.

The following section presents the results of the analysis of the policy documents, complemented and illustrated with excerpts from the expert interviews. The results are focused on the framing of the issue of health literacy within the plans and systematically structured according to Entman's [27] four dimensions of framing: problem definition, causal interpretation, moral evaluation and presented solutions. Each section is additionally structured along sub-headings; these mirror the main topics related to this dimension that were identified from the data.

3.2. Problem definition

The data show that developing a joint understanding of the problem, i.e. of limited health literacy, was important when developing an action plan. Often, this included agreeing on a working definition, which in turn helped to establish a joint focus for those who later wrote the plans. Problem definition also included highlighting the high prevalence of limited health literacy in the respective jurisdiction, the implications of limited health literacy on health, health inequalities, health service use and the economy.

3.2.1. Developing an understanding of health literacy and situating it in existing debates

While interviewees reported that coming to a joint understanding of the problem was crucial for advancing the topic, they also highlighted that agreeing on a problem definition often took con-

Box 1: Chronology of events related to the development of the four national action plans.

USA

In the US, the development of the national action plan was heavily triggered by findings from the 1993 National Adult Literacy Survey [34] and the 2003 National Assessment of Adult Literacy [35]. These two studies found that a significant amount of US adults had low literacy levels. These findings as well as other health literacy studies in clinical and medical journals that consistently found limited health literacy to be associated with worse health outcomes and higher health care cost, led to the publication of the "Healthy People 2010" programme [36], which set a national objective to improve the health literacy of the US population. The programme served as a stimulus for the US Department of Health and Human Services, the health department of the US federal government, to convene an inter-ministerial working group, thereby establishing a governmental structure that was legitimised to facilitate action on health literacy. The 2004 Institute of Medicine report on health literacy [37] supported proponents in moving the topic up the political agenda. Following the report's launch, the US Department of Health organised a one day Surgeon General's Expert Workshop in 2006 and town hall events in four American cities in 2007 and 2008. Health care organisations and providers, researchers, educators, and communicators participated in the workshops, whereas representatives from local organisations joined the town hall meetings. All events were geared at facilitating a multi-stakeholder process, increasing civil participation, and developing the "National Action Plan to improve Health Literacy", which was launched in May 2010.

Wales

In Wales, the trigger for taking action on health literacy was a National Strategic Public Health Framework mentioning the importance of health literacy for reducing health inequalities. Following heightened attention, the Welsh government commissioned Public Health Wales, the national public health agency in Wales, to conduct a review of the evidence and develop recommendations for action to improve health literacy. The review was conducted by a national group of experts from various sectors, which was appointed by NHS Wales and included organisations of the National Health Service (NHS), academic bodies, charities, the Welsh Assembly Government, and local authorities. NHS Wales also facilitated the development of recommendations through a multi-stakeholder process. Recommendations were initially suggested by the expert group and then reviewed and quality-assured in a consultation process with national and international experts, a team at Public Health Wales, and a patient group. "Health Literacy in Wales. A scoping document for Wales", a hybrid between a review of the evidence and an outline of a national strategy to improve health literacy, was published half a year after its commissioning in November 2010 by the Welsh Assembly Government.

Scotland

In Scotland, a study highlighting problems of dealing with health-related information among the Scottish population was published in 2009 [38]. Crucial for generating attention and triggering political action, however, was the passionate interest of Christine Hoy, a health professional seconded to the Scottish Government, who was instrumental in developing a chief medical officer's video outlining the difficulties and confusion that people experienced when interacting with the health service. Subsequently, the Scottish Government convened the National Health Literacy Action Group consisting of researchers, governmental and NHS representatives as well as third sector organisations. Chaired by the chief executive of a non-governmental organisation, the group developed the action plan through a series of meetings between November 2011 and May 2013. "Making it easy. A Health Literacy Action Plan for Scotland" as well as a web-based health literacy resource [39] and the Scottish Health Literacy Action Plan Implementation Group were launched by the Scottish Government in June 2014. In June 2017, the Government published a report outlining the progress of the plan's implementation [40]. A second action plan which built on the first plan was published in November 2017.

Australia

In Australia, health literacy has been discussed since the 1990ies [41,42], yet the first policy document that took up the topic was the 2009 National Mental Health Plan [42,43]. The date of publication coincided with the publication of the first population results on health literacy for Australia [42,44]. In the following years, several public health and health promotion policies addressed health literacy. An important trigger for political action came from the 2012 US Academy of Medicine report, which outlined ten attributes of health literate organisations [45]. By highlighting the organisational and systemic aspects of health literacy, this report generated attention for the topic at the Australian Commission on Safety and Quality in Health Care (ACSQHC), a national statutory body setting guidance on health care issues. In 2013, the ACSQHC conducted a literature review and developed a background paper on health literacy, titled "Consumers, the health system and health literacy: Taking action to improve safety and quality" [46]. The document was used as a basis for consultation, resulting in 114 responses from consumers, health professionals, ministries, patient organisations, and research institutions. Based on this feedback, an action plan titled "Health Literacy: Taking action to improve safety and quality" was developed. After launching the plan in August 2014, the ACSQHC developed additional resources, such as summaries and infographics for specific target groups, and organised a stakeholder workshop on how health literacy in Australia could be enhanced. Further support for the topic was galvanised by the national statement on health literacy, a short version of the action plan which highlighted the key points of the plan and was signed by the national committee of national and federal health ministers. Two subsequent Tasmanian action plans on health literacy referred to the Australian plan, suggesting that the topic was followed up at local level [47,48].

siderable time, because the various actors involved had differing views on the issue. As a Scottish interviewee put it:

> "We were getting to grips with it. [Agreeing on the problem] added to the time that it took to put together the plan. . .Because we all needed to be in agreement about what it was, about what we were trying to address, and about what people's understanding was of health literacy."

The interview data show that health literacy was often unknown as a term prior to the development of the action plans. Many interviewees reported that "lots of people didn't know what health literacy was" (Welsh interviewee) and that health literacy was "a rather new concept" (Scottish interviewee). Despite their unfamiliarity with the concept, stakeholders seemed to quickly realize that health literacy was useful as a concept that could be perceived as cutting across other, long-debated health systems' issues and as a potential frame for the identification of solutions to some of these underlying problems. This was, for example, evidenced by the statement of an Australian policymaker, who stressed that health literacy was perceived as being closely linked to adequate communication in health care institutions and thus to safety in health care:

> "What we realised was that there is a number of underlying cross-cutting issues for all of these tragic events that are happening in hospitals and primary care. And key to a lot of them is communication and health literacy."

Table 1
Synopsis of definitions of health literacy.

USA (2010)	Wales (2010)	Scotland (2014)	Australia (2014)
"Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."	Health literacy is "the ability and motivation level of an individual to access, understand, communicate and evaluate both narrative and numeric information to promote, manage and improve their health status throughout their life time¨	No definition of health literacy, but the plan highlights: M̈any of us lack the knowledge, understanding, skills and confidence to take an active role in our own wellbeing, despite a strong desire to do so.¨	"Health literacy is about how people understand information about health and health care, and how they apply that information to their lives, use it to make decisions and act on it.T̈hen, the report separates health literacy into two components: (i) individual health literacy, and (ii) health literacy environment.

3.2.2. Diverse definitions of health literacy

The findings reveal that the definition of health literacy was an important aspect of framing the problem, and that each action plan employed a slightly different definition (Table 1). The US and Welsh plans provided rather traditional definitions of health literacy, focusing on an individual's ability to obtain, process, understand, communicate, and evaluate information in order to manage their health. The Welsh plan additionally highlighted the importance of health literacy for promoting, managing and improving one's health status throughout the life span [49], while the US plan stressed HL as a prerequisite for making "appropriate health decisions" [50]. The Australian and Scottish plans placed a particular emphasis on contextual factors, including the health system, its procedures and actors. The Australian plan explicitly distinguished between individual health literacy and the health literacy of the environment [51].

Supporting the documentary evidence, the interview data also suggest that the term health literacy was contested: On the one hand, the term seemed popular and was perceived as providing an opportunity to grasp and newly brand the problem of inadequate communication in the health service. On the other hand, some interview partners reported that the term was perceived as unhelpful and as potentially distracting attention away from the deficiencies of the health care system and towards the individual. This was obvious in an interview with the Scottish policymakers who reflected:

> Interviewee 1: "I think the term's unhelpful."
>
> Interviewee 2: "Yeah, the term is fantastically unhelpful. . .Because it locates the problem with the illiterate person, not with the systems. . .If you could change it with a magic wand, it would be like: barriers to successful communication."

Accordingly, the interviewees highlighted that they had intentionally refrained from placing a particular focus on the concept or the term when developing the Scottish action plan. Instead, the emphasis had been placed on existing barriers in the health service and on potential ways of removing them, i.e. on the contextual factors.

3.2.3. High prevalence of limited health literacy

All action plans referred to the empirical evidence outlining the high percentage of the national populations who had problems in dealing with health-related information. The US plan built on the NAAL [50], the Welsh plan referred to Welsh data on general adult literacy and to a survey on chronically ill people's experiences of care [49], the Scottish plan referred to Scottish data on reading and numeracy and to studies which analysed English working-age adults' difficulties to deal with medication for children [52], and the Australian plan referred to the Australian Bureau of Statistics' work on health literacy [51].

3.2.4. Implications of limited health literacy on health, health inequalities, and health service use

The potential implications of the high prevalence of limited health literacy were then highlighted in all plans. In several action plans, scientific studies were mentioned, including studies on health inequalities, chronic disease, and the inadequate use of health services. Often, these studies were cited as postulating that health literacy and insufficient understanding of health information among the general population were linked to negative public health outcomes. For example, the plans stressed the associations between low health literacy and difficulties to manage one's own and other people's health and wellbeing, lower levels of self-reported health, the development of multiple health problems, poor health status, and higher mortality.

Drawing on evidence that disadvantaged population groups are particularly affected and vulnerable, the plans also highlighted that low levels of health literacy can contribute to health inequalities and inequities. All plans emphasised the relationship between low health literacy and inadequate health service use, mentioning, for example, lower uptake of health promotion and prevention services, medication errors, poor management of chronic conditions, more frequent use of emergency services, higher rates of hospitalisation, and longer hospital stays. The Scottish plan stressed that those with low health literacy take longer to access medical care, are less able to communicate with health professionals, and less likely to take part in health-related decisions, thus having difficulties in using services appropriate to their needs.

3.2.5. Financial implications

All plans also mentioned the financial implications of limited health literacy on the health system, with most plans drawing on US figures [23,53]. In line with the documentary data, interviewees stressed that highlighting the costs of low health literacy, for example due to "wasted medication, people coming back for appointments, hospital admissions and so on" (Scottish interviewee), had been important in persuading their target audiences. In fact, several interviewees highlighted that it had been important to stress that health literacy was not a "soft" topic, but had serious implications in terms of effectiveness, safety, and costs.

3.3. Causal interpretation

All plans provided some causal interpretation and drew attention to a number of factors that, according to their rationale, contributed to the problem of limited health literacy. The arguments for the rising importance of health literacy could be categorised into societal, systemic, and individual factors, with an overall recognition pervading the documentary and interview accounts that the combination of several factors exacerbated the problem of limited health literacy.

3.3.1. Societal developments

Several plans pointed to societal developments like an aging population, the increase in chronic diseases, and the exclusion of ethnic minorities as contemporary challenges, all of which were portrayed as enhancing the importance of health literacy. Referring to the growing prevalence of chronic diseases, the US plan, for example, highlighted that consumers increasingly had to make active decisions about their health care. Such arguments were strengthened by stressing that calls for consumer-driven care and shared decision making required patients to take a more active role in their health care. Plans also stressed the growing popularity of the internet and the availability of diverse information as placing increasing demands on the individual when making health-related decisions. Several plans concluded that health-related decisions had become more complex.

As an example, a Scottish policymaker highlighted the implications of societal developments on the relationship between service users and health professionals and stressed the need for interactions at eye level, better communication and increased efforts to jointly make decisions:

> "I think we are in a new environment, where information, access to information, wrong or right information, but access to information is powerful. Where the expertise does not always sit on the doctor's side of the table. And it is in this environment, that we need to have more equal relationships and greater dialogue."

3.3.2. Systemic deficits

Both documentary and interview data suggest that the plans were driven by a recognition that health systems had to change, because they were unable to meet patients' needs. In this context, the plans listed a number of system barriers, for example the existing hurdles that could erode an individual's confidence in accessing and participating in health care and their resultant reduced ability to sustain their health [52]. In order to highlight structural factors that impede effective interaction and reduce health literacy, the Australian plan mentioned the complex health system and its complex processes and policies, the unequal relationships between service providers and users, and poor communication. The later points were also picked up in other action plans which highlighted that the reality of the patient-provider-interaction differs sharply from the postulated vision of mutual, equal interactions, and that patients are often "part of an imbalanced health profession/patient relationship "[49], characterised by "information, status and power imbalances" [51].

While many plans stressed poor communication by the media, government and private sector agencies as a cause of limited health literacy, the strongest focus was placed on the communication between service providers and users. Here, the plans drew attention to the difficulties for patients in understanding the languages and processes of health services, which were exacerbated by the fact that patients were often simultaneously experiencing stressful health and life circumstances and "emotionally vulnerable situation[s]" [49]. The plans also claimed that "healthcare professionals underestimate. . .health literacy needs" [52] and drew attention to the resulting asymmetry and "chasm of knowledge between what professionals know and what consumers and patients understand" [50].

3.3.3. Individual causes

In terms of individual causes, several plans drew attention to the lack of both individual abilities when accessing health services and public awareness towards the problem of health literacy. By listing limited literacy skills, age, language, ethnicity, learning disabilities, and individual abilities to self-manage as contributing factors, the Welsh plan placed a particularly strong emphasis on individual factors.

3.4. Moral evaluation

All action plans employed a variety of moral arguments to support their calls for improving health literacy. The moral dimension of the health literacy debates was supported by a Scottish policymaker who reported that "there is something about health literacy being about values and feeding into lots of value-based conversations". The key moral arguments that were brought forward in the action plans were the right to good health and to manage one's own health, the right to good health care, and the responsibility of policymakers to take action to improve health literacy.

3.4.1. Right to good health and to manage one's own health

All plans highlighted citizens' rights to good health. They stressed that low health literacy is an impediment to health, longevity and quality of life and leads to poor health outcomes, thereby highlighting that limited health literacy contributed to citizens not being able to exercise their right to good health. A frequently promoted, related argument was that patients needed to be health literate in order to exercise their right to be active, equal partners in health decisions. Implications were drawn that health information and services had to be patient centered. The documentary analysis suggests that the emergence of health literacy provided opportunities to initiate debates about cooperative approaches to health care, about the "required shift in practice and culture" [52], and about the trust and positive relationships that were necessary to empower patients to take an active role in their health care. The following account of two Scottish interview partners suggests that talking about health literacy allowed proponents to sneak such broader topics into the policy debates:

> Interviewee 2: "A Trojan horse. It is a Trojan horse, yeah, it is. Absolutely. . ."
>
> Interviewer: "Health literacy as a Trojan horse for what?"
>
> Interviewee 1: "For a relational approach to health care that focuses on what matters to people."

Linking health literacy debates to debates on patient-centered care, several plans placed emphasis on "shared decision making" [49] and "informed consent" [51]. The US and the Australian plan explicitly stressed these aspects, highlighting that patients are entitled to receive accurate and actionable health information that is easy to understand and enables them to make informed decisions. Several interviewees, however, were eager to emphasise that health literacy did not automatically deliver shared decision making:

> "[Health literacy] is necessary but not sufficient [to achieve shared decision making]. That should be the way of thinking about it." (Scottish policymaker)

All plans highlighted the patient's right to exert control and exercise "choice or voice" [51]. Interviewees as well as action plans acknowledged that patients have to be health literate in order to exercise this right, to successfully navigate the health system, and to manage their own health and health care. The interview data suggest that in Scotland, improving patient empowerment actually seemed to be the driving force in the health literacy debates. A Scottish policymaker admitted:

> "I don't give a fig about health literacy levels. It's about: Is the person empowered to take decisions and actions that are in accord with what matters to them as a result?...What matters is the empowerment of people at the end." (Scottish policymaker)

3.4.2. Right to good health care

Drawing on patients' rights, the plans also promoted the right to good health care. One the one hand, plans highlighted that health services should be beneficial to, and supportive of, health and well-being. On the other hand, the cost-effectiveness [50], sustainability [49], and safety of health care [52] were also perceived as important aspects of good health care. Wrong medication and incorrect use of prescribed medication were given as examples to illustrate the need for action. The Australian plan placed a particularly strong emphasis on health literacy as a crucial contributing factor to the safety and quality of health care, on promoting patients as competent partners in health care delivery, and on depicting them as instrumental in safeguarding the quality and safety of the system.

3.4.3. Political responsibility

All action plans referred to existing legal frameworks from the health and education sectors to underline their calls for action and depict health literacy as a moral issue. The Australian and Scottish plans explicitly highlighted that health literacy is a political responsibility. Several plans also stressed that societies would benefit from good health literacy, for example by rationalizing that it "contributes to people's overall health, and consequently their capacity to participate and contribute productively to society" [51].

3.5. Presented solutions

All plans explicated what they wanted to achieve, and having a clear objective was reported as crucial in focusing the political debates and the development of the plans. An American policymaker reported:

> "Having an objective was crucial. It was very useful in keeping people on track."

An analysis of the documentary data shows that all plans prioritized awareness raising and the delivery of a strategy to improve health literacy, but that the suggested solutions how to achieve these aims differed considerably between the plans. The interview data suggest that while the available literature and evidence were important factors, existing and emerging policies, ongoing political debates as well as political support played a crucial role when developing solutions. Frequently, attempts seemed to be made to develop aims and recommendations that were aligned with existing policy approaches, political will, and the support from stakeholders, suggesting that the framing of solutions was strongly influenced by political and strategic considerations. Such considerations seemed to play a particularly important role in the relative importance that was placed on different solutions.

3.5.1. Improvement of information and communication

The quality of health-related information was highlighted in three of the four plans, with an emphasis on the need for accurate, accessible, and actionable information. Reference was also made to the development, spread and promotion of existing and new health literacy tools, innovations and technologies. In line with framing the problem as caused by inadequate communication between representatives of the health system and its users, the plans placed a strong focus on the need for effective and adequate communication. It was postulated that the health literacy of health professionals needed to be improved in order to achieve better communication. The Scottish plan specifically stressed the importance of transition points in health care as key learning points and ideal opportunities to enhance health literacy. The plans also acknowledged that improved communication required organisational support.

3.5.2. Systemic change and culture shift

In line with the acknowledgement that health literacy requires organisational improvements, the importance of structural and systemic changes to achieve sustainable improvement was highlighted in three of the four action plans (US, Scotland, Australia). The most frequently made recommendations were to embed health literacy into systems and organisations, changing policies, and building partnerships.

Calls for systemic change seemed to be particularly prevalent in Scotland. A Scottish policymaker elaborated on calls to remove organizational obstacles by drawing on the picture of hurdle racing:

> "We can see that there are barriers. . .It is on the people within the service to make their system more easy for people to interact with. A nation of expert hurdlers are not arriving, and they are not arriving quickly enough. And so we just need to make the road flatter and not have the barriers in the way, not have the hurdles there."

Similarly, another interviewee stressed that the "need to change as a service" as opposed to calling for individual change had been the primary focus of the political work that had been going on. Not surprisingly, the Scottish plan put a specific emphasis on sensitising health service providers to "shifting the focus" [52] and "making it easier" [52] for patients to access, process, and act on health-related information.

3.5.3. Awareness raising and provision of basic education

Raising awareness for health literacy was an explicit aim of all plans. Several plans mentioned the need to incorporate health literacy within education and lifelong learning. Educational and community facilities were called upon to contribute to raising awareness of, and improving, health literacy. Two plans (US and Australia) suggested incorporating accurate, standards-based, and developmentally appropriate health information and curricula in child care, schools, and other educational institutions including universities. The US and Welsh plans highlighted the crucial role of the community to strengthen the local provision of adult education, language instruction, and culturally and linguistically appropriate health information services and patient education.

3.5.4. Intersectoral action, research, and dissemination of good practice

The analysis of the documentary data shows that initiating intersectoral action to improve health literacy was a primary aim of all plans. This included "start[ing] discussions about. . .who can be involved in [the] processöf addressing health literacy systematically [51] or bringing together actors from different parts of society. The US and Welsh plans further stressed the importance of research in monitoring progress, developing and evaluating appropriate interventions, and improving health literacy. Similarly, the dissemination of good practice and the use of evidence-based health literacy practices and interventions were stressed as important components of an overall strategy to improve health literacy.

3.5.5. The balance between structural and individual solutions

While all plans drew attention to both systemic and individual approaches to improve health literacy, the interview data clearly show that deliberate decisions were made about the emphases placed on one or the other. First and foremost, these decisions seemed to be influenced by strategic considerations of what would be politically feasible. The interview data suggest that Public Health Wales' focus on the skills and abilities of the individual and his/her ability to self-manage had emerged due to strategic considerations:

> "It is tricky. It very much depends on who you want the responsibility to sit with. . .We thought it wouldn't really have a lot of

traction, because there were already so many initiatives which were trying to change what NHS Wales does and it wouldn't really work as a systematic approach. . ..At that point, NHS Wales had been through a massive change of the system. . .So if you had suggested a big move from the top – that would not go anywhere." (Welsh interviewee)

In contrast, a Scottish policymaker emphasised that the National Health Literacy Action Group that developed the Scottish action plan had made a conscious decision to focus on the barriers inherent in health service organisation, i.e. to shift the focus away from the individual and towards clarifying that the individual was not responsible for communication problems:

"If there is a health literacy problem, it is clearly the illiterate person that has the problem, which is *not* how we were approaching health literacy and seeing it. We were seeing it, following on from social definitions and social understandings of disability, as being a construct of the wider environment rather than the person. And the wider environment needs to adapt to the communication needs of the person." (emphasis added)

4. Discussion

Drawing on the action plans to improve health literacy of the US, Australia, Scotland, and Wales, this paper explores how health literacy is framed in contemporary policy debates and which factors influence the framing of health literacy. To our knowledge, this is the first analysis of framing in health literacy action plans. Our analysis allows the conclusion that the four dimensions of framing as identified by Entman [27] provide a useful analytical structure to systematically analyse framing in contemporary public health debates. Our analysis highlights three main aspects.

First, proponents of health literacy put considerable effort into framing the issue, i.e. into defining the problem of limited health literacy, providing rationales for the need for political action, evaluating the issue from a moral perspective, and developing appropriate solutions. Our analysis as well as recent efforts in some European countries to place the topic on the political agenda and develop action plans [25,26,54] provide evidence of the swiftly increasing political prominence of health literacy. Health literacy seems to constitute a policy issue that is being promoted successfully, at least in some political arenas.

Second, our analysis shows that health literacy debates can provide unique opportunities to direct attention to, and suggest solutions for, problems in the health system. It indicates that existing health literacy plans closely draw on major health care concepts, such as empowerment and shared decision making. Our analysis shows, for example, that policy debates on health literacy can be utilized to re-ignite discussions about the need for health care reform, a cultural shift in health care provision, and improved interaction between patients and health professionals. The fact that health literacy is a relatively novel term and concept that many policy actors, including policymakers, health service providers or those involved in the policy debates, are unfamiliar with, in some instances seems to allow health advocates to frame the debates in ways that help to refresh "old" and neglected issues, place them on the policy agenda and communicate related solutions in a different context [55]. It might be that the increased attention for social and technological change and digitalization and its potential impact on all aspects of everyday life might help to draw political attention towards issues like communication and literacy. The fact that several action plans refer to these societal changes suggests that drawing on these issues to frame health policy debates might have some traction. Our analysis also shows, however, that suggestions for action to improve health literacy largely reiterate well-known recommendations, which have been the subject of national and international policy debates for decades (e.g. the improvement of information, education and communication, organisational change, or the dissemination of best practice [cf. 56,57]). Overall, the reviewed health literacy plans fail to present innovative solutions.

Third, the analysis presented in this paper shows that health literacy is a concept that is hard to pin down. This finding is mirrored in the previous literature and the multitude of articles, which critically reflect on the different definitions of health literacy and on what the term should entail, and provide evidence of the various, and often conflicting, understandings, views, and perceptions of the concept [1,58]. Health literacy has often been referred to as a "relational concept", which captures the balance (or imbalance) between individual skills and abilities on the one hand and systemic and structural demands and organisational complexity on the other [10,21,59]. In line with the concept's dual nature, the framing of health literacy within existing action plans takes place along a wide continuum. Health literacy framing ranges from a focus on individual deficits and measures to improve individual capacities, knowledge or information to a strong emphasis on the importance of structural barriers and facilitators, systemic interventions and the need to change the health system.

Our analysis suggests that health literacy is a malleable topic. According to Smith, ideas that have chameleonic or vehicular qualities are ideas that can be pitched to different audiences in markedly different ways [60]. Chameleonic ideas are thus more likely to "survive" in policy debates, because they can be amended according to the course of political discussions and developments [60]. Hence, malleable or chameleonic ideas particularly lend themselves to political framing [61]. By remaining relatively unspecific in its definition and allowing actors to equally focus on individual or systemic factors and solutions, health literacy constitutes a malleable idea. On the one hand, this malleability provides manifold opportunities for framing and allows different actors to identify entry points into health policy debates; on the other hand, health literacy is hard to pin down and debates risk to remain vague and unspecific.

A number of limitations of our study need to be acknowledged. Our selection of policy documents was based on the outlined criteria, which means that recently developed action plans and those which are currently being developed were not included in the analysis. The data might further be biased in terms of regions and countries because only documents were included which had been published or translated into English or German. Due to the chosen selection criteria, political strategies which, for example, covered the topic in the context of other policy issues were also excluded from the review. We therefore cannot provide insight into how policy debates on health literacy – if at all existent – are framed in the context of other health policy debates or in legislatures which were not included in the analysis.

5. Conclusions

Our analysis of national action plans shows that health literacy is a concept which provides opportunities to instigate discussions about a variety of health policy issues. Health literacy seems to have been successfully used to shape debates on health system reforms, patient empowerment, and shared decision making. The analysis shows that health literacy can, if applied strategically, help to focus policy debates on key public health problems and towards the development of previously obstructed solutions. While the malleability of the concept of health literacy might help to identify common ground, the risk lies in the pursuit of strongly contrasting priorities and solutions and in promoting individual-level solutions to structural problems. By focusing health policy debates on the underlying systemic and structural causes of limited health

literacy, public health experts might be able to learn from previous experiences and seize the opportunities provided by emerging health literacy debates, namely to advance innovative solutions to neglected, but pressing public health problems. The insights provided from this analysis of existing national action plans on health literacy can inform the development of national action plans in legislatures which would benefit from tackling these problems.

Conflict of interest statement

HW, KH, AH and DS are part of a project aimed at developing a national action plan to improve health literacy in Germany. DS also led the first representative survey on health literacy in Germany (HLS-GER). OO is researcher at the Centre for Prevention and Intervention in Childhood and Adolescence (CPI) at Bielefeld University and in the "Health Literacy in Childhood and Adolescence (HLCA)" research consortium.

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