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# A Critique of the Transmission Model of Functional Health Literacy

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**Abstract:** *The author will explore the concept of functional health literacy through a critical analysis of the definition. Derived from a medical model, it serves as an information commodity within a human capital approach to literacy and healthcare, transmitting particular information, and reinforcing compliance with the existing system.*

## Purpose of This Exploration

The author will explore the functional health literacy concept through a critical analysis of the definition--examining its conceptual limitations and applications to real life settings. The functional approach, derived from a medical model, serves as an information commodity within a human capital approach to literacy and healthcare that depends on the transmission of particular information, and compliance with the existing system, "following the physician's recommendations faithfully and accurately in treatment and lifestyle." (Weiss in Giorgianni, 1998, p. 6). According to health literacy experts, "the goal is functional health literacy....working within a health system, having a dialogue with professionals and acting on this knowledge" (Rudd in Giorgianni, 1998, p. 8). Although there have been attempts to apply functional healthy literacy skills and tasks to other environments and practices (Rudd, Kirsch, & Yamamoto, 2004), it is this medical skills-based definition that predominates, setting a high bar for "the ability to perform basic reading and numerical tasks required to function in the health care environment" (Parker et al., 1999 in Greenberg, 2001, p. 69). Even those with higher levels of literacy find this environment difficult to navigate. Why does the health care industry demand this unachievable standard?

In a downsized health care system that relies on self-care, prevention, and with large social distances between providers and patients, in what has been referred to as "not just a gap, but a chasm" (Institute of Medicine, 2003, p. 1), functional literacy skills become significant for gaining access. Once inside, providers and patients are configured within a "partnership model" of service (Kerka, 2003), that would assume a care ethic and time to develop human relationships, but which instead focuses on providers pushing reading directives onto patients. This model invokes a discourse of choice and self-sufficiency for patients while protecting providers with clauses and recorded transactions, from possible lawsuits (see, Perkins et al., 1998). Self-management and perfunctory communication about health is promoted because "active patient cooperation [as, sic] essential to the success of most outpatient medical treatments." (Giorgianni, 1998, p. 13). The assumption is that "people must be able to advocate for themselves as they are increasingly seen as active consumers rather than passive recipients of treatment and care." (Osborne, 2004, p. 3). While the saturation of print and electronic information sources into medical interactions intensifies, and becomes naturalized and unquestioned, it burdens individuals to decipher solipsistic text in order to handle their own health problems. The quick fix remedy is to reduce these complex meanings to the most simplistic terms, through Plain Language (Brandt, 2001; Madden, 2002; Osborne, 2004). This entrepreneurial model shifts accountability away from the health industry and its financial interests, towards people's individual skills, ignoring the more salient conditions for poor health and literacy, like social class disparities and racial discrimination. This individualistic focus

unwittingly undermines the greater need for better welfare and public services in society for “vulnerable populations” (Chesnay, 2005).

A “literacy myth” (Levine, 1982) is reinforced with a formula for optimizing skills to increase health access and benefits: “*Health literacy*.... remains a neglected, final pathway to high-quality health care.” (Nielsen-Bohlman, Panzer, Kindig, 2004, xi). The fallacious functional health literacy, founded on, and rooted in a dysfunctional health care environment that depends on print transactions, becomes a self-fulfilling prophecy which more accurately should be renamed “healthcare literacy” (Giorgianni, 1998, p. 8). While the medical community has been targeted for change by those in public health to produce “cultural competence” (Ad Hoc Committee on Health Literacy, 1999) through better navigational features, the focus has been almost entirely on the low-literate patient to conform to standard medicalized norms, reinforcing “The Tyranny of Health Promotion” (Robertson & Minkler, 1994, p.296; Kennen, Martin, & Davis, 2004). These unexamined health literacy beliefs need to be examined within a critical framework.

#### *Introduction to Functional Health Literacy:*

Although there are a number of definitions (Osborne, 2004), the standard explanation of functional health literacy (FHL), found in the National Library of Medicine, 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.” (Ratzan & Parker, 2000, in Osborne, 2004, p. 32). Although international health work, since the 1960s has addressed health literacy (Chesnay, 2005), it was first coined in 1974, as part of a set of minimum standards for health education (Selden et al., 2000). Health literacy has since expanded, becoming a burgeoning agenda, spearheading adult literacy policymaking (see, Hohn, 2002) in what has opportunistically been referred to as a, “maturing partnership” between the fields (Rudd, 2002a) with a skills focus, and deficiency assumptions about people with low literacy. The cure is to improve their health through better risk communication and medical information (Hyde, in Osborne, 2002), for, “it is not easy to separate literacy from information-gathering or decision-making competency.” (Fortenberry in, Giorgianni, 1998, p. 10).

The transmission of certain skills, behaviors, and the use of established information-based systems for healthcare by individuals characterizes the functional “read to do” approach (Rudd, 2002b). The discourse of cooperation, consent, and compliance for conventional biomedical advice (Madden, 2002) are key underlying assumptions of functional health literacy, “as one component of functional literacy” and its systems-based transmission, “to enable people to seek and obtain effective health care” (Rudd in Levine, 2001, p. 16). Low functional health literacy, therefore, is equated with limited compliance with the health care system, with treatment plans, and minimal lifestyle change.

The functional health literacy construct was developed in response to the National Adult Literacy survey of 1992, (Singleton, 2002), and a decade later, thousands of citations could be found (Levine, 2001). Its expansion also reflects conservative educational reforms with endorsements for skills-based reading instruction, focused on “what works” (Erickson, 2005). This approach now adorns the adult basic education field, lending it an esteemed anchor in the sciences and an easily measurable, known quantity (functional literacy) with which to study and teach. Prescriptions for skills-based programming prevail with teachers encouraged to instruct students on health industry vocabulary.

Raising public awareness is a key factor in this “social marketing.” (Rudd, R., Moeykens, B., & Colton, 1999, p. 183) effort. Health Literacy month was inaugurated in October of 2000,

in what was referred to as a “grassroots campaign” (Osborne, 2005) to reduce health disparities through a diffusion model (Rudd, 2002a). This campaign would heed the call among public and private agencies to reduce the “alarming disparity between skills needed to comprehend and act upon basic health information” (Pfizer, 2001, p.1) among a “socially complex” (Smedley, Stith, & Nelson, 2002) population who devour health care costs for other members, and pose “a recipe for disaster” (Baker, 1997, in Giorgianni, 1998, p. 8).

The emergence of critical health literacy (Nutbeam, 1999, in Kerka, 2003) is important because it counters the myth of literacy as a commodity (Gee, 1996) about the accrual of information capital and health consumption. It focuses on community empowerment with critical analysis and social and institutional change. In this framework, health is viewed less as an individual scarce resource to stockpile, and more as part of building social justice collectively through popular education. Health education “empowerment” programs (Boudin, 1983; Norton, 1997; Sissel & Hohn, 1996), allow learners, programmers, and community health workers to analyze health problems and develop Freirean-based social action approaches. One example of this might be to educate about the aims and costs of pharmaceutical companies, like Pfizer (which funds health literacy projects), rather than just read its prescription labels. Yet a perusal of health literacy websites reveals instrumental, rather than political approaches to health literacy education (which has little sponsorship).

### **Bodies of Literature**

Four major bodies of literature will be focused on for the purpose of critiquing the functional health literacy concept. This literature includes: Law, Adult Literacy, Medicine, and Public Health (AHRQ, 2004, Brandes, 1996; Kerka, 2003; Sissel & Hohn, 1996; Rudd, Moeykens, Colton, 1999; Selden et al, 2000). Major studies are reported in this health literacy literature which illuminates four major weaknesses of functional health literacy that concern its validity and ethics: 1) The preliminary relationships between health and literacy found in the research but not in policy language; 2) the myopic attention to health literacy assessment; 3) the instrumental approaches to health education and cultural adjustment; and 4) the focus on technical communication and navigation problems of individuals, over structural problems in the health care system. A critical approach uncovers the ‘technical rational’ (Welton, 1993) assumptions underneath the functional health literacy concept.

The first point, concerning health-literacy relationships, illustrates the importance of “research literacy” (Merrifield, 1997), because while the policy language sounds definitive, the research is in more infancy stages. Conclusions are considered tentative and further research is needed to “clarify the magnitude of these relationships.” (Ad Hoc Committee on Health Literacy, 1999). They are limited because “studies identify individuals and groups in which only the print component of health literacy skills is measured” (Nielsen-Bohlman, Panzer, & Kindig, 2004, p. 67) and with this, a full range of print is not differentiated (Nielsen-Bohlman, Panzer, & Kindig, 2004, p. 49-50). Claims, for example, that, “improving people’s literacy skills can lead to improving their health” (Proliteracy, 2003, p. 15), need to be qualified and contextualized. The second point, concerning assessment, arose because patients might not tell doctors about their low literacy skills due to feeling ashamed (Parikh, et. al., 1996 in Greenberg, 2001) or, do not know they have low literacy (Kirsch et al., 1993). Consequently, assessments should be given. Yet these are problematic and as Greenberg (2001) has pointed out, there are some ethical and validity issues with regard to testing low-literate patients in medical facilities, especially when the vocabulary triggers anxiety, and they don’t mirror real-world tasks. The third point is that

health literacy curriculum tends to focus on ethnic and language cultural issues in a clinical way rather than systemic racism and classism; for example, a recent conference is entitled, "Culture, Language, and Clinical Issues: Operational Solutions to Low Health Literacy" (The 4<sup>th</sup> Annual Institute for Health Care Advancement, 2005). More compensation than, "cultural competence" is needed to rectify these inequities that reflect power relations in society. The fourth point piggybacks on the third, with the focus on communication competencies, "when words get in the way," (Rudd, 2002b) rather than inherent problems in the health care system. Bonny Norton (2000) found in her study of women second language learners, that power relations over communication competencies (which are highlighted in the SLA literature) inhibited the women from speaking to professionals. Although the health care system has been characterized as being in a disastrous state with more medical errors and patient complaints than ever before (Institute of Medicine, 2003), it is better oral and written communication tools (Hyde, 2002) that are the "prescription to end confusion" (Nielsen-Bohlman, Panzer, & Kindig, 2004). This declaration upholds the "toxic literacies" and power relations that bolster an inequitable system (Taylor, 1996).

### **Implications for Theory and Practice**

The development and transmission of functional health literacy has produced irrelevant health education protocols that reduces people's health problems to oral and written goods to be traded on the market. In a health transmission model (see, Rudd, 2002a), both medical providers and teachers, become change-agents to the "target population," teaching the words that are the cure, with the expectation that they will adopt instrumental knowledge in intended ways (Giorgianni, 1998, p. 21). The laser attention to functional health literacy, as a positive innovation to be adopted by patients, sidesteps a serious critique of the medical establishment, in terms of its domination by particular interest groups, their world views of disease etiologies, and their promotion of certain problems over others (O'Connor, 1995), for example, diseases with large lobbies. More importantly, it does not tap into the complex sociological variables that research has shown to be the crux of the problem, especially poverty, and lack of social capital (Aday 2001 in Chesnay, 2005). Critical literacies programs and models need to be better supported because they address the underlying factors of poor health and access, and see those with low-literates as agents of change too. By addressing the "indirect" issues that are most salient for low-literates' health problems (Singleton, 2002), advocates for health literacy may undercut their financing (from corporations like Pfizer) but boost their integrity and grassroots power and voice by focusing on systemic causes of poor health and access, like, lack of livable wages and poor labor conditions (see, Auerbach & Wallerstein, 2005).

It would be important to critique the political language of the helping professions (Edelman, 1975); the discourse of compliance cements the functional health literacy definition—safe and "false economies." (Levine, 1982), that mask deeper inequities. This human capital approach to health and literacy overlooks people's needs apart from the system and pathologizes them (Sticht, 1997). Perhaps Denny Taylor's prophetic words best sum up the technocratic functional health literacy paradigm best, in her book, *Toxic Literacies*:

In America, who lives and who dies is controlled by the subtexts of society. Official documentation hides the human rights violations that take place in this country. We enculturate members of our communities into poverty. Men, women and children are incapacitated by legally sanctioned discriminatory practices that occur through the use of bureaucratic texts. There is an official form to deal with every life situation. On paper,

whatever action is taken can be justified. It's all on the record. Through toxic forms of print we abdicate responsibility--even though we are not always aware of our duplicity." (1996, p. 14).

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