Health literacy research in the Nordic countries

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Introduction

Across the world, health literacy is gaining attention as a determinant of health. However, so far the research on health literacy has predominantly been produced by the US (Pleasant, 2012). Although research in Europe is increasing at an exponential pace (Quaglio et al, 2016), it is apparent that the Nordic countries Denmark, Finland, Iceland, Norway and Sweden have been relatively slow movers in contrast to, for instance, the UK, the Netherlands and the German-speaking countries Austria, Germany and Switzerland (Sørensen, 2013). Nevertheless, health literacy is now receiving more attention regarding health and welfare in Northern Europe.

Health literacy entails people’s knowledge, motivation and competences to access, understand, appraise and apply health information in order to make judgements and decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life course (Sørensen et al, 2012; see also Chapter 1, this volume). Furthermore, health literacy can be functional, interactive or critical, dealing with different aspects of managing health (Nutbeam, 2006, 2008; see also Chapter 14, this volume).

Low health literacy is associated with poor health and a low level of education (Berkman et al, 2011; HLS-EU Consortium, 2012), and low functional health literacy is also associated with increased use of emergency care (Morrison et al, 2013), poorer ability to interpret health messages and lower participation in prevention (Berkman et al, 2011). Notably, the prevalence of limited health literacy is linked to a wide range of disparities (Paasche-Orlow et al, 2005; see also Chapter 9, this volume) and injustices (Volandes and Paasche-Orlow, 2007).

This chapter provides a broad overview of health literacy research conducted in the Nordic countries and discusses the scope and scale of how health literacy is addressed. Future avenues on how to manifest health literacy on the Nordic health agenda are discussed in the Conclusion.
Nordic Health Literacy Network

Health literacy research in Europe is steadily evolving (Quaglio et al., 2016), and the European Health Literacy Survey (HLS-EU) accelerated the process and acted as a catalyst for many more countries to follow up with more research (see Chapter 8, this volume). For the first time the HLS-EU provided comparative population data on health literacy in a number of European countries. It revealed that limited health literacy varied from 29 per cent to more than 60 per cent among the eight countries that participated, which included Austria, Bulgaria, Germany, Greece, Ireland, the Netherlands, Poland and Spain (Sørensen et al., 2015). In addition, more European countries have added to the evidence base such as, for instance, Belgium, the UK, Serbia, Kosovo and Switzerland (Jovic-Vranes et al., 2011; Bostock and Steptoe, 2012; Wang et al., 2012; Toçi et al., 2013; Vandenbosch et al., 2016). So far, however, the Nordic countries have scarcely been represented in the evolving European health literacy field (Wångdahl and Mårtensson, 2013).

Brought together by the fact that no Nordic countries had participated in the survey, researchers from Denmark, Norway and Sweden joined forces to discuss how awareness of health literacy in the region could be improved. In response, the Nordic Health Literacy Network was established in Copenhagen in April 2012 to bridge the gap in the lack of research from the Nordic region. Later, members from Finland and Iceland also joined. Since the launch of the Network meetings have taken place in Copenhagen, Oslo, Gothenburg, Aarhus and Brussels. The Network aimed at identifying common grounds concerning research, funding opportunities and to raise awareness among other stakeholders to mobilise progress in research, policy and practice from a Nordic point of view.

Examples of concrete activities undertaken by the Network include a collaborative funding application to the Nordic Council of Ministers and a pre-conference in association with the 2nd European Health Literacy Conference in Aarhus, Denmark and the 3rd European Health Literacy Conference in Brussels, Belgium. Furthermore, the translation of the term ‘health literacy’ into Nordic languages has been part of an ongoing debate within the Network. Table 13.1 illustrates the most prominent translations used in Danish, Finnish, Icelandic, Norwegian and Swedish. Notably, the way that health literacy is translated reveals insights into how the term has been interpreted and perceived in the various

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<tr>
<th>Language</th>
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<td>Danish</td>
<td><strong>Sundhedskompetence</strong>, health literacy</td>
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<td>Finnish</td>
<td><strong>Terveyden lukutaito</strong>, <strong>terveysosaaminen</strong></td>
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<td>Icelandic</td>
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<td>Norwegian</td>
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<td>Swedish</td>
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national contexts (Sørensen and Brand, 2013). However, it should be noted that often the term ‘health literacy’ is applied directly in its original form in English in the various Nordic languages, similarly to the practice used regarding the word ‘empowerment’.

**Nordic health literacy research**

The first two Nordic health literacy publications were published in 2008, and the number has slowly increased since. Studies on health literacy are published in a variety of scientific journals reflecting the great span of topics that it is associated with. The studies also vary according to their methodological designs. Unfortunately, no research has yet been published from Iceland.

**Denmark**

The first study from Denmark was published by Bo and colleagues (2014), who performed a population-based assessment of the dimensions of health literacy related to understanding health information and to engaging with healthcare providers using the Health Literacy Questionnaire (HLQ). They then examined associations between socioeconomic characteristics with these dimensions of health literacy. Between 9 and 20 per cent perceived health literacy tasks as difficult or very difficult. Low levels of the two dimensions were associated with low income, low education level, living alone and to non-Danish ethnicity, and associations with sex and age differed by the specific health literacy dimension (Bo et al, 2014).

The study was followed up by Friis and colleagues (2016) to quantify levels of subjective health literacy in people with long-term health conditions (diabetes, cardiovascular disease, chronic obstructive pulmonary disease [COPD], musculoskeletal disorders, cancer and mental disorders), and to compare these to levels in the general population and examine the association between health literacy, socioeconomic characteristics and comorbidity in each long-term condition group. The study revealed that people with long-term conditions reported more difficulties than the general population in understanding health information and actively engaging with healthcare providers. Wide variation was found between disease groups, with people with cancer having fewer difficulties and people with mental health disorders having more difficulties in actively engaging with healthcare providers than other long-term condition groups. Having more than one long-term condition was associated with more difficulty in engaging with healthcare providers and understanding health information. People with low levels of education had lower health literacy than people with high levels of education. Friis et al (2016) recommend that more effort should be made to respond to the health literacy needs among individuals with long-term conditions, multiple comorbidities and low education levels, to improve health outcomes and to reduce social inequality in health.
To develop health-literate organisations (Brach et al., 2012) it is important to address people’s health literacy when providing healthcare (see Chapters 8 and 31, this volume). Health professionals should be aware of and have an insight into people’s health literacy when they provide health services. Therefore, health professionals need to be health literate themselves. The study by Elsborg and colleagues (2017) examined the level of health literacy in students in Denmark attending one of four full university programmes related to health, and investigated how their health literacy was associated with their sociodemographic background. The health literacy levels of the students were measured using the HLQ, and it was administered through the students’ Facebook groups. The study showed no gender difference, although female students scored higher than male students regarding social support for health. Students attending the public health programme tended to score higher, and those attending molecular biomedicine tended to score lower regarding health literacy. There was a positive correlation between health literacy and the educational level of the students’ parents. If one of the parents was employed in the healthcare sector, the health literacy score tended to be higher in some aspects. The same held true for students who had been hospitalised. The study concluded that students’ health literacy relates to their personal background and educational path. Hence, this may be important when planning curricula for developing the health literacy of future generations of health professionals (Elsborg et al., 2017). Kayser and colleagues tested the HLQ for use regarding eHealth and developed the eHealth Literacy Questionnaire (eHLQ), a multidimensional tool based on a well-defined a priori eHLF framework with robust properties. The questionnaire is designed to be used to understand and evaluate people’s interaction with digital health services (Kayser et al., 2018).

Emtekaer Haesum and her team (2015) validated the Test of Functional Health Literacy in Adults (TOFHLA) for adaptation to the Danish setting and culture. It was satisfactorily tested among patients with COPD and a case group through face-to-face interviews (Emtekaer Haesum et al., 2015).

Lastly, research has shown that developing health literacy in early life is critical to reducing lifestyle-related diseases, with schools being identified as central settings for this purpose. Bruselius-Jensen and her colleagues (2017) designed an educational programme, IMOVE, to develop health literacy related to physical activity. IMOVE contributed to the development of functional health literacy by building a relational understanding between everyday practice and step numbers. The presence of interactive health literacy was observed in discussions. However, only a limited number of discussions supported the development of critical health literacy. The research implies that educators can successfully integrate health literacy development into a classroom-based curriculum teaching with pupils’ own step counts and associated reflections positively influencing learning (Bruselius-Jensen et al., 2017).
Finland

In Finland, Paakkari and colleagues (2012) also concentrated on health literacy in schools. They explored how health literacy could be defined as a learning outcome in schools with a focus on five core components: theoretical knowledge, practical knowledge, critical thinking, self-awareness and citizenship. They argued that one of the main aims of health teaching in schools should be to foster students’ ability to define their own beliefs, identity and social relations along with ethical reflections (Paakkari and Paakkari, 2012; see also Chapter 34, this volume). Based on these findings they recommended three approaches for health education in schools: facts and skills, individual thinking and personal growth and citizenship (Paakkari, 2015). The approaches differ in complexity and can be used in planning for learning experiences aimed at supporting the development of higher levels of health literacy. Furthermore, they can be used in teacher training when the aim is to help teacher trainees become aware of their current ways of seeing school health education, and the differences that may exist between their understanding and more complex forms of understanding (Paakkari, 2015). Paakkari and colleagues (2017) also studied health literacy in relation to participation in sports club activities among adolescents. The aim was to compare levels of perceived health literacy among adolescents who do or do not participate in sports club activities. The settings approach was chosen as organised sport club activities reach a high proportion of adolescents and have the potential to contribute to the development of their health literacy. The study was conducted as a part of the Health Behaviour in School-Aged Children (HBSC) study, using the Health Literacy for School-aged Children (HLSAC) instrument. Sports club participation and its association with health literacy were examined in relation to age, gender, family affluence, school achievement and physical activity. The study indicated that perceived health literacy was higher among adolescents who participated in sports club activities. This conclusion was valid for boys and girls, for both age groups, among those who were physically active 6–7 days a week, had at least moderate school achievement, and those who belonged to middle or high-income families. From the health literacy perspective, participation in sports club activities was especially beneficial for those having low or moderate school achievement levels. Notably, the sports club setting may work towards equalising health literacy differences related to school achievement. However, the clubs should ensure that access is available to as many adolescents as possible, thereby spreading beneficial influences and supporting the development of health literacy among broader population groups (Paakkari et al, 2017).

In turn, Parisod and colleagues (2016) explored the determinants of health literacy in the context of tobacco-related information from the perspective of young adolescents. Today’s adolescents are used to a constant information flow, but many face difficulties in processing health-related information due to low health literacy. There is still a need for deeper understanding of the determinants of health literacy in relation to adolescents to guide the development of health
literacy instruments and interventions. A qualitative study including 10 focus groups was conducted in two schools in Finland, one representing a typical Finnish public school with students following a general curriculum and the other a Finnish public school with students with special educational needs. The results showed that the young adolescents pointed out new mediating determinants that influence health literacy which are not included in current adolescent-specific models of health literacy. These newly found determinants require attention and further exploration. The acquired knowledge can be used to strengthen existing adolescent-specific health literacy models and as a basis for health literacy instrument and intervention development (Parisod et al, 2016).

Eriksson-Backa and her colleagues (2012) examined the health information literacy of elderly Finns and found significant relationships between education level, interest in health information, seeking activity, self-rated current health and dimensions of health information literacy. Some elderly people are more vulnerable regarding obtaining and use of health information, for instance, those with lower levels of education, those with poor health and those who are not interested in and active in seeking information. The study highlights that health information providers should ensure that available health-related information is understandable and can be accessed without too much effort (Eriksson-Backa et al, 2012). Health information literacy was also studied among young healthy men and adults with an increased risk for metabolic syndrome. The study revealed that adults with increased risk for metabolic syndrome seemed to value health information but had more difficulty in knowing who to believe in health issues and understanding the terminology used. The difficulties applied especially to respondents aged 35 or older. Men, and especially young men, had lower motivation than women in seeking health information (Enwald et al, 2016).

Norway

Gele and her team (2016) from Norway highlight health literacy as the missing link in improving the health literacy of Somali immigrant women in Oslo. They conducted a cross-sectional study using the European Health Literacy Questionnaire (HLS-EU-Q) in its short form. The findings revealed that 71 per cent of Somali women in Oslo could not obtain, understand and act on health information and services and make appropriate health decisions. Being unemployed and socially less integrated were independent predictors of an inadequate health literacy among the Somali women who participated. Gele et al (2016) conclude that enhanced health literacy will most likely increase the chance of better health outcomes for immigrants, thereby moving towards health equity in Norwegian society. Hence, policies and programmes are required to focus on and improve the health literacy of immigrant communities in the future (Gele et al, 2016).

The study by Fredriksen and colleagues (2016) focused on maternal health literacy. The internet is one of the fastest growing information sources for pregnant
women, and seems to be used across social and economic strata. However, knowledge on how interaction in web-based discussion forums influence maternal health literacy, regarding how pregnant women access, appraise and apply information to promote and maintain good health, is still lacking. The aim of this study was therefore to explore the role of interactions in web-based discussion forums among women who experienced health problems during pregnancy. More specifically, to explore why media-literate women experiencing the medically unexplained condition, pelvic girdle pain (PGP), during pregnancy participated in web-based discussion forums and how they appraised and applied the information and advice that they gained from the web-based interaction with other women. In the study, women were invited to participate via postings on three different open websites for pregnant women and mothers, the data were collected using synchronous qualitative email interviews and were analysed using thematic analysis. Notably, the study indicated that interaction in web-based discussion forums influenced maternal health literacy in terms of increased health-related knowledge and competencies, increased awareness of health promotion and health protection, and increased system navigation. The women appraised and selectively applied information and advice that resonated with their own experiences. For many, the information provided online by other women in the same situation was valued more highly than advice from health professionals. Women reported that they used their knowledge and competency in encounters with health professionals but hesitated to disclose the origin of their knowledge. Those with a high level of education in medicine-related fields raised a concern about the internet as a source of horror stories and erroneous information, and were actively engaged in trying to minimise potential negative effects by providing biomedical information. The lessons learned highlight that professionals need to recognise that pregnant women access web-based discussion forums for support and information to increase their ability to take better health decisions for themselves. Web-based fora are therefore a potential resource that health professionals may find useful in consultations with pregnant women (Fredriksen et al, 2016).

On another note, one Norwegian study (Bjørnsen et al, 2017) explored mental health education because mental health literacy is an asset for health that educational initiatives can strengthen, and it is a significant determinant of mental health. The study showed that positive mental health literacy was significantly related to adolescents’ mental wellbeing. The authors recommend positive mental health literacy concerning how to obtain and maintain good mental health as an integral component of school health services’ mental health education among adolescents (Bjørnsen et al, 2017).

Switzerland

Swedish researchers were among the first to adopt and explore the concept of health literacy in the Nordic countries. The research has primarily focused on measurement, refugee health literacy and cancer screening.
Health literacy is an important determinant for health and a valuable health indicator within public health. As such, it is a significant outcome variable of health promotion efforts. Valid and reliable instruments are needed to evaluate health promotion interventions and to assess levels of health literacy in a population. One of the few measurements of communicative and critical health literacy is the Japanese Communicative and Critical Health Literacy scale (C & C HL scale), which was validated by Wångdahl and Mårtensson (2014). To make it possible to use this instrument in Sweden, the C & C HL scale was translated into Swedish and different aspects of validity were tested among health experts and bilingual people. The study indicated that the Swedish C & C HL scale was understandable and showed evidence of content validity as the items cover the major aspects of communicative and critical health literacy as identified in the original tool, and are understandable and stable over time, that is, reliable (Wångdahl and Mårtensson, 2014). Wångdahl and colleagues (2015) also validated the Swedish version of the Functional Health Literacy test (S-FHL) from Japan to be used in health promotion and disease prevention. They concluded that the Swedish version of the scale was equivalent to the original Japanese scale concerning language and contents. The scale is reliable and shows consistency over time (Wångdahl and Mårtensson, 2015).

**Mental health literacy**

The evidence in Sweden suggests that mental health literacy among the public is low and stigmatising attitudes are widespread. So far, the effects of anti-stigma campaigns have been small, and studies demonstrate that negative attitudes have been quite stable through recent decades (see Chapters 4, 17, 19 and 24, this volume). Hence, Svensson and Hansson’s study (2016) aimed to explore the relationships between mental health literacy, experience of mental illness and stigmatising attitudes/social distance towards people with depression or psychosis. It included a cross-sectional study in which staff members from public services in Sweden completed questionnaires covering demographic data, self-reported experience of mental illness, identification of a vignette for depression or psychosis, beliefs about helpful interventions for the illness presented in the vignette, and attitudes and social distance towards people with the illness. The results showed that half of the participants could identify depression and less than 40 per cent psychosis. A higher degree of mental health literacy was related to less stigma and social distance but mainly towards people with depression. A similar relationship was shown for having personal or family experience of mental illness and attitudes/social distance. Negative attitudes and social distance were significantly higher in all aspects measured towards a person with psychosis than a person with depression. Notably, a higher degree of mental health literacy relates to more positive attitudes and less desire for social distance towards people with depression (Svensson and Hansson, 2016).

Melas and colleagues (2013) studied mental health literacy among adolescents using two pre-established vignettes that presented an adolescent with symptoms
of either depression or schizophrenia. The data were analysed both qualitatively and quantitatively. Interestingly, the data showed that 42 and 35 per cent of the respondents were able to identify depression and schizophrenia, respectively. Depression was recognised more often by females than males. Professional help was suggested by a minority of the respondents for managing symptoms of depression only. Altruistic behaviours, examined through willingness to help an acquaintance with mental illness symptoms, were apparent among almost 60 per cent of the respondents and to a greater extent in females than males. In turn, stigmatising attitudes were identified with relations to schizophrenia in 12 per cent of the participants. Mental health literacy was relatively low among teenagers in Sweden. Raising awareness through introducing psychoeducation in the school curriculum is therefore recommended (Melas et al, 2013).

**Health literacy of refugees**

Refugees have poorer health compared to indigenous populations, which may be explained by lower health literacy, that is, not being able to access, understand, appraise or apply health information. Wångdahl and colleagues’ study (2014) aimed to determine levels of functional and comprehensive health literacy, and factors associated with inadequate health literacy, in refugees coming to Sweden. A cross-sectional study was performed among adult refugees speaking Arabic, Dari, Somali or English at language schools for immigrants using the European Health Literacy Survey Questionnaire (HLS-EU-Q16) and S-FHL. The results showed that the majority of the participating refugees had inadequate or limited functional health literacy (60%) and comprehensive health literacy (27%). Low education and being born in Somalia were factors associated with an increased risk of having inadequate functional health literacy. Also, having inadequate functional health literacy was associated with an increased risk of having inadequate comprehensive health literacy. It can be concluded that the majority of refugees in the language schools had limited or poor health literacy. Health literacy should therefore be taken into consideration in contexts and activities addressing migrants (Wångdahl et al, 2014). A follow-up study explored the refugees’ experiences of communication during their health examination and its usefulness in association with their health literacy. The study applied the S-FHL test and the HLS-EU-Q16. The results showed that in the health examination for asylum-seekers, a poor quality of communication was experienced by 36 per cent, receiving little information about healthcare by 55 per cent, and receiving little new knowledge by 41 per cent and help by 26 per cent. Having inadequate as compared to sufficient comprehensive health literacy was associated with the experience of a poorer quality of communication and the experience of receiving little valuable healthcare information. Furthermore, having inadequate as compared to sufficient comprehensive health literacy was associated with the experience of not receiving new knowledge or receiving help with health problems. It could be concluded that the refugees’ experiences indicated that a
low level of comprehensive health literacy could act as a barrier to fulfilling the purposes of the health examination for asylum-seekers. Furthermore, it seems that comprehensive health literacy seems to be of greater importance in this context than functional health literacy (Wångdahl et al, 2015). In continuation, Wångdahl and her colleagues (2018) wanted to study comprehensive health literacy in more depth using HLS-EU-Q16 in association with general health, psychological wellbeing and having refrained from seeking healthcare among refugees in Sweden. The study was conducted with approximately 500 refugees speaking Arabic, Dari and Somali. Notably, the majority of the participants had limited comprehensive health literacy, and four out of ten reported poor health and had refrained from seeking healthcare (Wångdahl et al, 2018). More research is needed to better understand health literacy among refugees and to develop strategies and methods to increase health literacy, promote optimal health-seeking behaviour and make life easier for those with low health literacy (see also Chapter 17, this volume, on the mental health literacy of refugees in Canada).

In Sweden, according to Svensson and colleagues (2017), migrants have poorer sexual and reproductive health compared to the general population. Health literacy, in the form of the cognitive and social skills enabling access to health-promoting activities, is often poorer among migrants, partly due to language and cultural barriers. Therefore, culturally sensitive health education provides a strategy for enhancing health literacy. Since 2012, specially trained civic and health communicators have provided sexual and reproductive health and rights information to newly arrived refugees in Skåne, Sweden. The aim of this study by Svensson and her colleagues was to explore how information on sexual and reproductive health and rights was perceived by female recipients, and whether being exposed to such information contributed to enhanced sexual and reproductive health and rights literacy. Semi-structured in-depth interviews were conducted with nine women and analysed using qualitative content analysis. Two themes emerged: opening the door to new understandings of sexual and reproductive health and rights and planting the seed for engagement in sexual and reproductive health and rights issues, illustrating how cultural norms influenced perceptions, but also how information opened up opportunities for challenging these norms. Notably, it should be recognised how gender-separate groups may facilitate information uptake while discussion concerning sexual health norms may benefit from taking place in mixed groups (Svensson et al, 2017).

Lastly, Wangmar and colleagues (2018) explored health literacy and views about being invited to screening among participants and non-participants in a national colorectal cancer screening programme. Sweden has not yet implemented a national screening programme for colorectal cancer, but a nationwide study is ongoing. Previous research has shown that the use of healthcare services, together with several health-related outcomes, is associated with an individual’s level of health literacy. However, the relation between health literacy and participation in colorectal cancer screening has produced varying results reported within the few studies addressing this issue, and so further research is warranted. The study
revealed that the majority, whether they were participants or non-participants in the screening programme, had an acceptable level of health literacy and no significant differences in health literacy levels between the groups were found. Participants expressed that it was important and appreciated to be able to choose information sources on an individual basis. Among non-participants, the importance of receiving invitations with a clear message that quickly draws one’s attention was highlighted. However, both groups expressed a positive outlook towards the invitation. A majority of individuals displayed acceptable levels of health literacy, regardless of whether they chose to participate or not. Similarities between the groups were seen in the qualitative findings regarding views of the invitation. The findings indicate that in the future a more dynamic approach could be valuable to increase clarity in the message about the importance of screening (Wangmar et al, 2018).

Scope and scale of health literacy in Nordic countries

The research presented here reveals a wide scope in how health literacy has been studied in a Nordic context. The topics have ranged from population health literacy to the health literacy of refugees, health literacy in schools, mental health literacy among adults and adolescents, validation of measurements and health information literacy regarding screening and different diseases. Although the Nordic countries are welfare countries, the studies reveal the clear health literacy divide that challenge the people’s response to what is offered through health and social services. Studying the health literacy scale in more depth, the studies so far indicate that 10–20 per cent of the population and often those more in vulnerable groups are subject to suffer from limited health literacy, which hinders equal access to healthcare and preventive means.

Whereas this chapter has focused primarily on recent health literacy research conducted in the Nordic countries, it should be noted that health literacy projects and interventions are currently being carried out in all five countries, although they have not yet been published. While political buy-in is generally weak, a variety of stakeholders from practice have embraced health literacy as an important cornerstone for their health-related activities. One example is the MILSA project from Sweden that educates communicators to help migrants in understanding and navigating the health system (Länsstyrelsen, 2018).

While health literacy has been embraced and integrated more quickly by other European healthcare systems, it has been less prominent in the Nordic countries until a few years ago. One barrier could be the inconsistent translation of the term so that research efforts have not been mainstreamed. A second barrier could be the fact that the Nordic countries presume themselves to be well developed and focus to a high degree on empowerment and self-management. However, recent research from all five countries shows that health literacy remains a challenge that cannot be neglected. Notably, health literacy research seems to have gained momentum, which is promising for the years to come. Furthermore, the Nordic
Health Literacy Network has become involved in preparations for the second wave of the HLS-EU, and time will show how health literacy will evolve further in policy, research and practice in Denmark, Finland, Iceland, Norway and Sweden.

**Conclusion**

It is of the utmost importance that health literacy is addressed more strongly in the Nordic health agendas in the future and the new research developments as described in this chapter are promising. Proposals for action include national action plans on health literacy, health literacy included in the curriculum at all levels, the development of health-literate organisations that facilitate people-centred health and a monitoring programme that follows health literacy developments. More research is warranted to provide the evidence to decision-makers to engage more strongly in improving health literacy for all. The Nordic countries have the means and ability to address the health literacy divide, and the Nordic welfare model building on universal health coverage makes a solid foundation for creating health-literate organisations and, in turn, health-literate communities and people.

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