Health-literate healthcare organisations

Jürgen M. Pelikan

Introduction

There has been a rapid increase in the number of publications on health literacy in general, but also specifically on organisational health literacy, health-literate healthcare organisations (HLHCOs) or health-literate organisations (HLOs). The discourse on HLOs, like the one on health literacy, started in the US, but has increasingly been taken up, adapted and further developed in other countries such as Australia, Austria, Belgium, Canada, Germany, Italy, Israel, Norway, Taiwan and New Zealand, and there are already several literature reviews or overview articles on organisational health literacy (Palumbo, 2016; Brach, 2017; Meggetto et al, 2017; Farmanova et al, 2018; Lloyd et al, 2018) that support orientation about this rapidly evolving field of research, practice and policy.

While from its beginning health literacy was introduced as a measurable and modifiable concept, based on the long tradition of measuring and teaching literacy, instruments for HLO measurement and modification are still being developed. Measurement of the functional health literacy of patients had already begun in the US in the 1990s, and produced empirical evidence that health literacy matters for healthcare: first, a considerable number of patients have low or limited (functional) health literacy, and this proportion is likely to increase (Parker et al, 2008). Second, patients with low (functional) health literacy have higher use and worse outcomes of healthcare services (Berkman et al, 2011; Brach et al, 2012). And third, low health literacy in healthcare also has considerable consequences for the costs of health care (Eichler et al, 2009).

These facts, taken up by the former Institute of Medicine and supported by the health policy of the US government, led to a focus by practitioners and researchers on the limited health literacy of patients within the healthcare system. Different single strategies were tried out, such as measuring patients’ health literacy to take low health literacy into account in communication; improving the readability of written health materials; improving oral communication by enhancing the communication of health professionals; using specific techniques such as the teach-back method in the clinical encounter; and improving access to services and navigation among facilities. Step by step these strategies were integrated into more systemic, holistic frameworks (Nielsen-Bohlman et al, 2004; Paasche-Orlow et al, 2006; Rudd and Anderson, 2006; Andrulis and Brach, 2007; Schillinger and
Keller, 2011), resulting in the *Ten attributes of health literate health care organizations* (see Brach et al, 2012).

A precondition for defining the concepts of HLHCO, HLO or organisational health literacy was the evolving understanding of health literacy as relational or interactive (Pelikan and Ganahl, 2017), individual vs system-related (Baker, 2006; Rudd and Anderson, 2006), contextual (Nutbeam, 2008) or dual (Parker, 2009), which partly resulted from interpreting the low health literacy of patients in the US healthcare system. This understanding acknowledges that an actual individual’s health literacy does not depend on their personal skills or competencies alone, but also on the complexity, that is, the demands and resources, of the situations in which health-literate decisions or actions have to be taken. By this understanding, not only can personal health literacy be measured and improved, but also situational, organisational or settings and systems-specific health literacy or health literacy sensitivity.

The meaning of ‘health’ and ‘literacy’ in health literacy has broadened in parallel, from focusing just on disease in clinical healthcare to also including positive health and wellbeing as understood in public health, disease prevention and health promotion, and from just understanding health-related information to also accessing, appraising and using it (Sørensen et al, 2012; Pelikan and Ganahl, 2017). Thus, health literacy and organisational health literacy are relevant for people in many roles besides being patients, such as, for example, for workers, consumers and citizens in all kinds of organisations, settings and systems in late modern society (Kickbusch and Maag, 2008). Therefore, the concept of a health-literate organisation or organisational health literacy is now also used for cities, schools, workplaces etc. While the limited space of this chapter does not allow to expand on these conceptual expansions, the World Health Organization’s (WHO) *Health literacy: The solid facts* (Kickbusch et al, 2013) gives some overview on this ongoing development.

The leading questions for this chapter are: (1) How is OHL in relation to health services, or specifically HLHCO, defined and conceptualised? (2) What instruments have been developed to assess and improve organisational health literacy/HLHCO? (3) What are the experiences of implementing the concept and using the tools in different healthcare contexts? And what are the barriers and facilitators for implementing organisational health literacy/HLHCO?

**Development of a holistic, systems-oriented concept of health-literate healthcare organisations**

In the US the organisational health literacy/HLHCO concept was developed in parts by different authors (Adams and Corrigan, 2003; Nielsen-Bohlman et al, 2004; Rudd et al, 2005; Paasche-Orlow et al, 2006; Rudd and Anderson, 2006; Andrulis and Brach, 2007; Schillinger and Keller, 2011) before being integrated into a more comprehensive framework by a task force from the Institute of Medicine of the National Academies in the US, which proposed the *Ten attributes*
of health literate health care organizations (see Brach et al, 2012). Following this conceptual breakthrough, instruments to assess the organisational health literacy of healthcare facilities and tool boxes of best practice interventions to improve it have been further developed, and hospitals and healthcare organisations have begun to implement the concept. In the US, the concept has also been differentiated for specific organisations of the healthcare system, for example, hospitals, pharmacies or other PHC (primary healthcare) facilities.

**Terminology and definitions of organisational health literacy**

‘Health literacy’ is still an evolving concept (Nutbeam, 2008), and for ‘organisational health literacy’ this is even more so. For health literacy, at least in the English language, there is a fixed commonly used term, but variation in defining its meaning. In contrast, for organisational health literacy, several different terms have been proposed, and not always explicitly and clearly. Therefore, they may or may not also signal differences in the intended meaning of the concept. In a recent article ‘What’s in a name? An overview of organizational health literacy terminology’, Meggetto et al (2017) gave an overview of the terms used and definitions proposed, as well as analysing the underlying dimensions and discussing the pros and cons of the existing variety of terms. They identified 19 different terms or phrases to describe organisational health literacy: environmental health literacy, health literacy environment, health literacy friendly, health literacy practice/s, health literacy responsiveness, health literacy system-level infrastructure, health literacy universal precaution, health-literate healthcare organisations, health-literate health service, health-literate organisation, health system health literacy, health-literate workplace, improving health literacy in services, organisational capacity to address health literacy, organisational health literacy, organisational health literacy responsiveness, provider health literacy, workforce health literacy, and workplace health literacy. This list does not yet take into account some further terms used in the literature, such as ‘health-literate settings’, ‘health literacy–friendly settings’, ‘health literacy–friendly organisations’ (Kickbusch et al, 2013), ‘health-literate society’ (Paasche-Orlow et al, 2006) or ‘health-literate America’ (Nielsen-Bohlman et al, 2004).

For further analysing the differences in terminology of organisational health literacy the linguistic aspects and differences in use of language in different communities have to be taken into account. Underlying the concept of organisational health literacy is the difference of people vs situations or personal vs situational, as proposed by Kurt Lewin (1982). For organisational health literacy for the ‘situation’, as the object referred to, different kinds of specifications are offered – either more abstract nouns like ‘environment’, ‘organisation’, ‘workplace’, ‘setting’, ‘service’, ‘system’, ‘society’, or also a process like ‘practice’. Also, further specified composites by prefixing additional terms have been used, like ‘healthcare’ or ‘health’, for example, most prominent ‘healthcare organisation’, or other functional or institutional concepts like ‘education’, or also quite concrete ones.
like ‘America’. Instead of ‘situational’, other adjectives like ‘environmental’ or ‘organisational’ were also used. But these kinds of differences in terminology are not a problem. Partly they reflect an affiliation to different scientific or practice discourses, for example, ‘health-literate settings’, to the health promotion discourse. By choosing a specific term, an author just indicates to which objects other than people they want to relate health literacy. And usually these terms denote clearly enough which kinds of objects are focused on (just a specific healthcare organisation or the all-embracing health system or the whole of society).

More critical is the use of the terms ‘health literacy’ or further developed ‘health literacy responsiveness’ as nouns or as adjectives ‘health-literate’ or further developed ‘health literacy-friendly’ or ‘health literacy-responsive’ or ‘health-literate healthcare organisation’ to denounce the way a non-personal object puts demands on or deals with the (personal) health literacy of the people it affects. What is meant by the ‘health literacy’ or ‘health-literate’ component is much more open to interpretation, since health literacy is an evolving concept (Nutbeam, 2008) with limited consensus on its meaning. Therefore, an author has to make explicit what they mean by organisational ‘health literacy’. For example, in the context of healthcare, is it only about the health literacy of patients or also of staff and of citizens in the community served by an organisation? Or is it just taking differences in the given health literacy of patients adequately into account, or does it also intend to improve their personal health literacy to empower them to effectively self-manage chronic conditions? Or is it just about making information and communication more understandable or also more accessible, appraisable and usable? Or is it just limited to clinical interaction, or does it concern all aspects of a healthcare organisation? These possible conceptual meanings of ‘health literacy’ in organisational health literacy must be explicitly stated by an author, to indicate what they intend by the term.

But the different terms used in the organisational health literacy discourse must not automatically indicate a different understanding of the content or scope of organisational health literacy; often they just relate to different reform discourses or try to be linguistically more correct or specific. Meggetto et al (2017), in relation to the three most commonly used terms — ‘health system health literacy’, ‘organisational health literacy’ and ‘health literacy practice’ — also came to the conclusion, ‘it is evident that the three dominant terms … are not mutually exclusive but rather interrelated’ (Meggetto et al, 2017, p G).

Concerning explicit definitions proposed for organisational health literacy or HLHCO, just three are presented here. First, an early one for ‘health literacy environment’: ‘The health literacy environment of a healthcare facility represents the demand side of the equation suggested by the IOM (2004) – the expectations, preferences, and skills of those providing health information and services’ (Rudd and Anderson, 2006, p i). Second, the probably most quoted definition for ‘health-literate healthcare organisations’ is: ‘Health care organizations that make it easier for people to navigate, understand, and use information and services to take care of their health’ (Brach et al, 2012, p 1). Third, a rather cumbersome but more
extensive and up-to-date definition that tries to explicitly integrate the content of the Brach et al (2012) definition with the comprehensive definition of health literacy of the HLS-EU Consortium (Sørensen et al, 2012, p 3) is:

A health literate healthcare organization makes it easier for all stakeholders (patients/relatives, staff/leadership and citizens) to access, understand, appraise and use/apply disease- and health relevant information and tries to improve personal health literacy for making judgements and taking decisions in everyday life concerning healthcare (co-production), disease prevention and health promotion to maintain or improve quality of life during the life course. To achieve this comprehensive concept systematically and sustainably, a healthcare organisation will have to apply principles and tools of quality management, change management and health promotion and to build specific organizational capacities (infrastructures and resources) for becoming more health literate. (Pelikan and Dietscher, 2015b, slide 16)

Concepts, models and frameworks of organisational health literacy

An up-to-date overview article (Farmanova et al, 2018, based on Farmanova, 2017) on the theories, frameworks, guides and implementation issues of organisational health literacy identified 15 conceptual papers that focus either on the ‘what’, that is, creating a vision, and/or on the ‘how’, that is, proposing operational frameworks to support action. These conceptual papers have also been presented in a complex conceptual and chronological map of organisational health literacy. For the ‘what’, seven theories have been identified (Paasche-Orlow et al, 2006; Andrulis and Brach, 2007; Coughlan et al, 2013; Kickbusch et al, 2013; Frosch and Elwyn, 2014; Pelikan and Dietscher, 2015b; Trezona et al, 2017) and discussed in some detail. Of the seven, two recent frameworks (Pelikan and Dietscher, 2015a; Trezona et al, 2017) and also one by Kickbusch et al (2013) have been highlighted as visioning organisational health literacy as a more complex phenomenon. The Vienna concept of health-literate hospitals and healthcare organisations (V-HLO) (Pelikan and Dietscher, 2015a) ‘present a broader understanding of health literacy as coproduction of health, quality, and safety; health promotion; and “healthy settings”’. Similar to Kickbusch et al (2013), the authors of V-HLO also call for the wider application of health literacy beyond health care’ (Farmanova et al, 2018, p 4). In contrast, ‘Trezona and colleagues (2017), in their empirically developed Organisational Health Literacy Responsiveness (Org-HLR) framework, “conceptualize health literacy as an issue of healthcare responsiveness”’ (Farmanova et al, 2018, p 4). But ‘both V-HLO and Org-HLR focus on developing organizational capacities, structures, and processes to support action on health literacy’ (Farmanova et al, 2018, p 4).

For the ‘how’ of organisational health literacy, nine operational frameworks were identified (Andrulis and Brach, 2007; Schillinger and Keller, 2011; Brach et al,
2012; Hernandez, 2012; Parker and Hernandez, 2012; Koh et al, 2013; Rudd et al, 2013; ACSQHC, 2014; Frosch and Elwyn, 2014; Palumbo and Annarumma, 2014; Dietscher and Pelikan, 2017; Trezona et al, 2017) and integrated into the conceptual map of organisational health literacy. For these, the underlying disciplines used for operationalisation, such as ‘organisational behaviour, healthcare management, implementation science, and quality improvement’ (Farmanova et al, 2018, p 4), or frameworks they relate to, such as the Balanced Scorecard, the Chronic Care Model or the Health–Literate Care Model (Koh et al, 2013), were described. Due to limitations of space, only two frameworks are highlighted in somewhat more detail here – the Institute of Medicine’s *Ten attributes* and the V–HLO.

**Institute of Medicine’s model of a health-literate healthcare organisation**

The discussion paper, *Ten attributes of health literate health care organizations* (Brach et al, 2012, p 19), published by the Institute of Medicine of the National Academies, proposes a list of attributes ‘that health literate health care organizations can adopt and invest in to help everyone benefit fully from the nation’s health care system’ (see Box 35.1).

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**Box 35.1: Ten attributes of health-literate healthcare organisations**

A health-literate healthcare organisation:

1. Has leadership that makes health literacy integral to its mission, structure and operations
2. Integrates health literacy into planning, evaluation measures, patient safety and quality improvement
3. Prepares the workforce to be health–literate and monitors progress
4. Includes populations served in the design, implementation and evaluation of health information and services
5. Meets the needs of populations with a range of health literacy skills while avoiding stigmatisation
6. Uses health literacy strategies in interpersonal communications and confirms understanding at all points of contact
7. Provides easy access to health information and services and navigation assistance
8. Designs and distributes print, audiovisual and social media content that is easy to understand and act on
9. Addresses health literacy in high-risk situations, including care transitions and communications about medicines
10. Communicates clearly what health plans cover and what individuals will have to pay for services

*Source: Brach et al (2012)*

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For each of these attributes a description and rationale are given and a list of more detailed characteristics – including already available assessment or intervention tools – is provided.

A closer look at the ten attributes reveals that these relate to different underlying dimensions. Only attributes 5–8 define the specific health literacy content of a healthcare organisation, that is, the accessibility and design of all its channels and materials for information and communication. Attributes 1–3 define general organisational preconditions that are necessary for systematically integrating a quality aspect or quality criterion into the totality of an organisation. These aspects therefore have to be observed in change management and organisational development generally. Attribute 4 relates to the value of participation, which is a core principle in person-oriented healthcare, in quality management and in health promotion. Attributes 9 and 10 highlight specific aspects of healthcare where adequate information and communication is specifically important or relevant in the US healthcare system.

In its conclusion, the discussion paper (Brach et al, 2012, p. 19) wisely summarises:

The concept of “health literate health care organizations” will profit from further discussion and refinement. The many examples in this paper, however, demonstrate that health care organizations can immediately take concrete, practical actions to close the gap between individuals’ health literacy skills and the demands of complex health care systems. The transformation to a more person-centered health care system provides opportunities to redesign health information and services, integrating principles of health literacy into organizational objectives, infrastructure, policies and practices, workforce development, and communication strategies. If health care organizations adopt most of the 10 attributes in even a modest way, they will not only be more responsive to individuals’ needs, and especially those with limited health literacy, they will also make a substantial contribution to improved population health.

The discussion paper (Brach et al, 2012) started a new phase in the organisational health literacy discourse.

**Vienna concept of health-literate hospitals and healthcare organisations (V-HLO)**

In the US the Ten attributes were taken up in different ways by practitioners and researchers (Brach, 2017). In Europe a team in Vienna/Austria (Pelikan and Dietscher, 2015a; Dietscher and Pelikan, 2017) started to develop a more comprehensive framework for a HLHCO with a focus on hospitals (V-HLO). In comparison to the Ten attributes, the V-HLO explicitly relates to the health promotion settings approach by using a simplified model of the 18 health-promoting hospitals strategies (Pelikan et al, 2005). Instead of a list, a matrix
model was used to define the content of organisational health literacy in V-HLO. The scope of included stakeholders was also extended from patients and their families to the staff and citizens in the catchment area of the hospital. The scope of content was widened from taking the given health literacy of patients adequately into account for better healthcare to also improve the personal health literacy of all stakeholders for disease management and prevention, and for lifestyle development. The V-HLO also uses the comprehensive definition of health literacy of the HLS-EU Consortium (Sørensen et al, 2012), by which health literacy is about finding, understanding, appraising and applying health-relevant information for judgement and decisions in everyday life concerning healthcare, disease prevention and health promotion.

But in V-HLO health literacy is not only understood as a core concept of health promotion, but like health promotion, also as a core aspect of quality in healthcare. Therefore, to make the implementation of health literacy in healthcare more acceptable and compatible for management and health professionals, and to support systematic implementation, the quality methodology of the International Society for Quality in Healthcare (ISQua) was applied to develop and define nine standards, with 22 sub-standards and 160 indicators for self-assessment of organisational health literacy, as a first step for improving it. This tool was piloted and validated in nine Austrian hospitals (Dietscher and Pelikan, 2017). In the meantime, the tool was translated into English, French, Italian and Mandarin and an international Working Group within the Network of Health Promoting Hospitals and Health Services (HPH) is further improving and validating it for use in different languages and healthcare systems (see Box 35.2).

**Box 35.2: The nine standards of a health-literate organisation**

The nine standards of a health-literate organisation are to:

1. Provide (organisational) capacities, infrastructures and resources for health literacy in the organisation
2. Develop and evaluate materials and services in participation with users
3. Qualify staff for HL communication
4. Develop a supportive environment – provide navigation assistance
5. Apply HL communication principles in all routine communications – in spoken, written, audio-visual and digital communication and by providing interpreting and translation support
6. Improve personal HL of patients and significant others by learning offers
7. Improve personal HL of staff by learning offers
8. Improve HL in the organisation’s community and catchment area
9. Share experiences and be a role model for HL in the healthcare community

*Sources: Pelikan and Dietscher (2015b); Dietscher and Pelikan (2017)*
Guides and toolkits for assessing and improving organisational health literacy

In their overview, Farmanova et al (2018) identified 20 health literacy guides and described these in a table, ordering the guides chronologically and giving information relating to the country, the objective, the healthcare sector, the focus, health literacy elements included and scoring possibilities of the guides. Furthermore, the guides were evaluated based on six health literacy dimensions (access and navigation, communication, consumer involvement, workforce, leadership and management, and meeting the needs of the population) and on eight quality improvement characteristics (form team, set aims, assess, establish measures, communicate and raise awareness, develop action plan, test changes, and track progress/sustain efforts). Summing up, Farmanova et al (2018, p 6) found:

Guides vary in their scope (single- to multiple-issue) and context to which they apply. The majority of guides were developed for healthcare organizations in general; 6 are specialized for primary care practices, hospitals, and pharmacies, and one is designed to support health-literate nursing practices…. Most guides combine an assessment of health literacy barriers and an action plan for improving OHL.

In summary it can be said that a great variety of tools already exist to support the implementation of organisational health literacy for different kinds of health services, but for practitioners it might be beneficial to further map, integrate and standardise these tools.

Empirical research on implementing organisational health literacy concepts and guides

Farmanova et al (2018, p 12) summarise their findings: “Thirteen reports published in 2008–2017 described the use of health literacy guides (Barrett et al, 2008; Groene and Rudd, 2011; Weaver et al, 2012; Callahan et al, 2013; Shoemaker et al, 2013; R.O. White et al, 2013; Zanchetta et al, 2013; Batterham et al, 2014; A. Johnson, 2014; Palumbo and Annarumma, 2014; Briglia et al, 2015; Adsul et al, 2017; Brach, 2017). The majority of these reports described the use of assessments of health literacy barriers (Groene and Rudd, 2011; Weaver et al, 2012; A. Johnson, 2014); few reports detailed implementation of organisational health literacy (Callahan et al, 2013; Briglia et al, 2015; Brach, 2017). Although these studies do not allow us to comprehensively assess evidence of the effects of organisational health literacy and the application of the guides, they demonstrate that the guides can facilitate action to remedy health literacy barriers (Groene and Rudd, 2011; Weaver et al, 2012; Brach, 2017; Dietscher and Pelikan, 2017), to adopt specific health-literate practices (Callahan et al, 2013; Briglia et al, 2015; Brach, 2017), and to understand the complexity of organisational health literacy and the factors influencing health-literate practices (Weaver et al, 2012; Batterham...
Organisations commonly modified existing guides to local context (Callahan et al., 2013; Brach, 2017), and used two or more health literacy guides (Weaver et al., 2012, Briglia et al., 2015) at the same time. A health literacy universal precautions toolkit (DeWalt et al., 2010; Brega et al., 2015; Cifuentes et al., 2015) was favoured in chronic disease management (Callahan et al., 2013), health promotion and disease prevention interventions (M. White et al., 2013), and to inspire the adoption of system-wide policies and procedures across healthcare organisations (Brach, 2017). The use of assessment tools provided with the guides was regarded as a useful and feasible exercise to provide direction for improvement (Groene and Rudd, 2011; Weaver et al., 2012; M. Johnson, 2014); it required few organisational resources, and caused little to no interference with patient care (Groene and Rudd, 2011). A particular guide, however, was perceived as complex and with limited value (Shoemaker et al., 2013). The use of health literacy guides could be enhanced if the guides had a clear relative advantage, were simple and adaptable, and if support with implementation was provided or barriers to organisational health literacy removed (Shoemaker et al., 2013). This appraisal is mostly supported by another systematic review (Lloyd et al., 2018).

From the reviewed studies Farmanova et al. (2018) have extracted a list of 13 common key barriers (or facilitators) for implementing organisational health literacy. These include, specifically related to organisational health literacy, the lack of awareness of, of seeing the advantages of, of commitment to, of priority of, of support from leadership for, of training for, of resources for, of time for, of procedures, policies and protocols for, of change champions for, of a culture of change and innovation for, of not too complex tools and guides for organisational health literacy. Critical for successful implementation is the presence of advocates for change, support from leadership and of a supporting management structure and culture for innovation and quality improvement. But these identified barriers and facilitators are not specific for implementing organisational health literacy; they hold true for all change management in healthcare facilities and far beyond. Therefore, it makes sense to integrate HLO into quality management in healthcare. More implementation research is definitely needed, but this research should focus on the specifics of organisational health literacy, and not just on the common challenges and problems of changing healthcare organisations.

Furthermore, as argued by Brach (2017) for the US, Lloyd et al. (2018) for Australia and Pelikan and Dietscher (2015a) for Austria, for successful implementation at the organisational meso level it is important to have adequate support by health policy at the societal macro level. One way to do this is to include organisational health literacy standards or indicators in health service accreditation systems (Meggetto et al., 2017).

**Summary and conclusion**

Low health literacy is more widespread in patient and general populations than expected by health professionals, but it has detrimental impacts on the use and
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outcomes of healthcare for patients. Since there is a social gradient for health literacy, as a determinant of health it also contributes to creating the health gap. Therefore, taking the low health literacy of patients better into account in healthcare by decreasing the demands of health services and improving health literacy by offering patient and health education can enhance the quality of healthcare and the health of people, and also contribute to lowering the health gap.

To realise this, a number of single interventions and measures are available that can be implemented by healthcare facilities. But for more comprehensive and sustainable results, an integrated, complex, whole systems approach is recommended. The concept of HLHCO, available in different, but overlapping, versions, provides such a model. A number of different tools are available to systematically assess organisational health literacy in healthcare as a necessary precondition for starting organisational development, learning or change processes towards a more health-literate organisation. But, as the limited and already existing research literature confirms, implementing a complex concept into the existing structures, processes and culture of an organisation is quite a demanding challenge. Therefore, more and better research on furthering and hindering factors for implementing the specific concept of HLHCO or organisational health literacy is needed.

The experience in the US and in some other countries like Australia, Austria, Canada and Germany shows that widespread and effective implementation at the meso level of healthcare organisations needs supportive regulations, incentives and resources from the societal macro level of health policy. Health policy should include organisational health literacy in national health targets or action plans and integrate organisational health literacy standards or indicators into healthcare accreditation systems. To better enable take-up by politicians and practitioners and comparability of research, more consensus on the terminology, concepts and definitions, models and measurement would be welcome, while allowing some lee-way for variety and internal differentiation of the concept and its tools. The newly founded Action Network on Measuring of Population and Organizational Health Literacy (M-POHL) under the umbrella of the European Health Information Initiative (EHII) of WHO–Europe will contribute to achieve this (https://m-pohl.net/).

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M-POHL (no date) WHO Action Network on Measuring Population and Organizational Health Literacy (https://m-pohl.net/).


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