A lifespan perspective on health literacy: Ageing and end-of-life issues

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Introduction

Developmentalists group late adulthood and older groups in slightly varying age groups as understandably this may change numerically or linguistically, varying by culture or society. This chapter focuses on the normative developmental process of ageing in the context of health literacy, utilising literature and anecdotal examples, and perspectives from those who care for our very valuable older population. Those who are older, in particular, the frail elderly, suffering from poor physical and mental health, or who have other co-morbid chronic diseases, access more services (including A&E), accumulating higher costs (see Chapter 10, this volume). Leaders in the field have promoted broader more ecological models of health literacy, although by and large these mainly apply to adults (Kickbusch, 2001; Kerka, 2003; Zarcadoolas et al, 2005, 2006; Nutbeam, 2008; Freedman et al, 2009; Sørensen et al, 2015). There is little published literature addressing health literacy across the lifespan, particularly towards the end of the life cycle. No matter what culture, subculture or country one is from, it is clear that similar issues ensue. Health literacy affects all, from economically disadvantaged and other marginalised groups, to anyone who accesses healthcare in person or online. Our ageing population is both cherished and at times a somewhat neglected group. Future generations can benefit from interactions with older groups, finding ways to support elders, and better understanding the concepts of death and dying. This in turn builds more positive and healthier communities. It is clear that collaboration, improving communication, highlighting community strengths, being inclusive of varying perspectives, can extend through the end of the life cycle, benefiting all in both the short and long term:

Growing old can be a matter of growing deep. It doesn’t always happen, but the opportunity is there. (Moore, 2004, p 300)
Overview

A lifelong learning perspective can enhance our understanding of the various competencies acquired over the lifespan, how they interact and, most importantly, how they are likely to contribute to improvements in individual and population health, a reduction in health disparities, potential monetary gains in governments that promote health education and health promotion, and intergenerational gains for overall health. Regarding the ageing population, the defined age groups include the young old (60–75), the old (75–85) and the oldest old (85 and older). Aspects of chronic health issues are highlighted in the context of the groups addressed in this chapter (for chronic disease and health literacy, see Chapter 12, this volume). The aim of this chapter is to address perspectives and related health literacy interventions with a particular focus on ageing, death and dying issues. Health literacy is seen beyond an individual-level issue, as a social or community-level issue. How we define ‘ageing’ or use language to address the concepts of disease, the challenges faced by caretakers and the overall grief and bereavement process at the end of life is emphasised.

Ageing and end of life: related interventions and perspectives

There is little published literature addressing health literacy across the lifespan, particularly towards the end of the life cycle. A systematic review of eight articles, all relating to urban settings in the United States, conducted by Chesser et al (2016), reported significant associations between low health literacy and poorer health outcomes, mixed findings in the associations between medication management and health literacy, whereby the authors emphasise a ‘need for a standardised and validated clinical health literacy screening tool for older adults’ (2016, p 1). However, this and other related research, leads one to question whether medical models traditionally focusing on ‘evidence’ in the US (Payer, 1996) can or should apply throughout the globe, or whether sharing perspectives and looking at things from a grey zone can contribute more effectively with less burden on healthcare professionals and systems. Notably, the burdens of economic crises (Kentikelenis et al, 2011), overburdened staff and medical mismanagement, whether public or private settings, have largely negative consequences in health-related outcomes, infrastructures and societies (Dunbar et al, 2011).

The strengthening of social capital, which is building networks (formal or informal) at individual or community level for social gain, is one area that several studies looking at adult populations focused on (Black et al, 2013; Yang et al, 2013; Kim et al, 2015). These studies demonstrate the benefits of building social capital including two large-scale Asian studies of over 1,000 people each in the respective countries of South Korea and Taiwan. Specifically, the South Korean sample demonstrated that social capital could attenuate the effect of low functional health literacy on health information resources, efficacy and behaviours (Kim et al, 2015). The study from Taiwan looked more closely at social capital networks,
concluding that females and those with higher education have higher health literacy, as well as those they deemed to have ‘higher health communication ability’ based on a six-item scale that measured the ability to communicate in a clinical setting, with no differences found by age and income (Yang et al, 2013, p 900).

The human development field and specifically the lifespan perspective, from pre-birth on, helps us better understand age-related changes in our behaviour, thinking, emotion and personality development (Boyd and Bee, 2012). Both personal and collective health literacy can be viewed as an interactive dance and the importance of our social and work-related environments as key issues in public health (Nutbeam and Kickbusch, 2000; Kickbusch, 2001; see also Chapters 14 and 23, this volume). The oldest old is the fastest growing in advanced economies like in the US, and there are challenges related to health literacy such as the quality of healthcare (Parker et al, 2016). It is clear from existing data that those who are older, particularly the middle aged to the elderly, and those who suffer from poor physical and mental health, access more services including A&E, often have other co-morbid chronic illnesses, and accumulate higher costs in already economically disadvantaged societies, including those in economic crisis (Kentikelenis et al, 2011; Lahana et al, 2011; Kondilis et al, 2012, 2013; Simou and Koutsogeorgou, 2014; Sørensen et al, 2015). Overburdened systems and a lack of resources can lower the quality of care, the spread of hospital pathogens, medical personnel likely burn-out, which in turn leads to medical mistakes and the likelihood of patient death, as best described in Deadly healthcare (Dunbar et al, 2011).

Some projects specifically focus on ageing and improving health literacy, such as the European ‘Intervention Research on Health Literacy among Ageing Population’ (or IROHLA programme), looking at the population aged 50 and above (EuroHealthNet, nd). IROHLA launched in 2012, reviewed ongoing health literacy programmes and projects, and identified and validated a set of 20 interventions or evidence-based guidelines, in what they indicate is part of a comprehensive approach for addressing the health literacy needs of the ageing population, with 22 European partners – a multidisciplinary group including universities, public health agencies, organisations representing older people, healthy cities, companies and businesses. Examples of the IROHLA health literacy focal points include computer literacy or digital literacy (for example, using computer and software for practical tasks), cultural literacy (understanding similarities and differences in customs, values, beliefs of one’s own culture and the cultures of others), financial literacy (ability to understand and take adequate actions in budgeting, accounting for income and expenses), information literacy (ability to know the need for information and to be able to identify, locate evaluate and effectively use this information), media literacy (informed, critical understanding of the mass media) and visual literacy (ability to understand and produce visual messages) (see www.irohla.eu/about/health-literacy).

Similarly, the American Association for Retired Persons (AARP), in a blog post by Flowers (2015), indicates that low health literacy costs billions to the medical system, and lists several priority areas for older adults, including making
wise insurance coverage decisions, navigating the healthcare system (including filling out complex forms or locating providers and services), sharing personal information such as health history with providers, engaging in self-care including chronic disease management (indicating that four out of five older adults suffer from at least one chronic condition), and finally, taking medications correctly.

These projects can also provide valuable information for countries with ever-changing population landscapes due to globalisation, as indeed ‘advancing health literacy’ continues to be the global challenge for the 21st century (Nutbeam and Kickbusch, 2000), and notably even more so for immigrant or transient groups.

Psychotherapist Thomas Moore, author of several therapeutic and self-help-oriented books, talks about the concept of age and ‘ageing’ in his book *Dark nights of the soul*, specifically, the concept of age being what we imagine it to be and that ageing is not imaginary – it is real, although we should not lose touch with our youth (Moore, 2004, p 290). The desire for younger people to be older or older people to be younger sometimes leads to quests for the fountain of youth, some focusing only on death, and with ageing, besides failing physical strength, there is an entire world of feelings, images and thoughts that can lead to greater powers of mind and imagination. In discussing living ‘more vigorously with an open heart’ (Moore, 2004, p 300), Moore states the experience in many older people of melancholy that ‘often characterises aging’, but it is only a tone of everything one does and it is not the same as depression (2004, p 295). He refers to the life review, mirroring the Eriksonian theory of psychosocial development for older adults and the stage of ‘ego integrity versus despair’, where those who achieve ego integrity must come to terms with who they are and have been, how they lived their life and the choices they have made, as well as opportunities gained or lost (Boyd and Bee, 2012, p 460). Moore (2004, p 299) reminds us that one of the greatest things we can do as human beings is to ‘raise a child who is happy and wise’, and be good neighbours and involved citizens. One could argue that this is reflective of the relationship between the micro and macro levels when we talk about ‘building’ health-literate societies, although this is not explicit in any of the texts discussed here.

The burden of caring for the sick and ageing, having proper living arrangements in the later years and access to appropriate care cannot be ignored from the ageing and health literacy equation – all these factors are influenced by an individual’s ability, their resources (social, financial), societal viewpoints and policy. Cultures strong in filial piety, the belief in the duty to care for elders, may also be influenced by their financial situations and the eventual adoption of more Western-style government programmes for the elderly (Boyd and Bee, 2012). More elders in countries where they are not restricted to work past a certain age are currently choosing to work after retirement (Boyd and Bee, 2012), and according to the Society of Actuaries’ (2011) 2007-11 report, out of those interviewed, about 45 per cent indicated they do not expect to retire, and it seems the reasons are to mostly prevent a drastic decline in their living standards. As societies we need to account for phenomena such as economic crises where younger people have
to work long hours, emigrate to other countries or regions to work and cannot
care for their elders themselves, and restrictive economic policies can lead to a
drastic reduction in all government spending, limiting access to care and increased

**Challenges and opportunities of contemporary society**

To live well in our contemporary and ever more global society requires having
competencies in a range of literacies, among them reading literacy, computer-
technological literacy, financial literacy, science and civic literacy, to name a few.
This is often referred to as the field of ‘new literacy studies’ (Gee, 1991; Street,
1995, 2003). As contexts and culture may vary, so do the effects of different
literacies under differing conditions (Street, 2003; see also Chapters 36 and
39, this volume). Ageing and the seemingly ‘digital divide’ (Sarkar et al, 2011)
may prove that those who have higher competencies in the afore-mentioned
literacies may have an advantage by being knowledgeable and using technology
(from computers to smartphones), although having access does not necessarily
assume one will be ‘successful’ during one’s older ageing years, physically or
socially. The European Health Literacy Survey (HLS-EU) data collected across
eight European nations indicated that those aged 50+ who are less educated,
and those who perceive their health as ‘bad’, have lower overall health literacy
(Sørensen et al, 2015; see also Chapter 8, this volume). Contrarily, in smaller
‘cultures’ (cultures within cultures), those living in small towns or villages, who
may have better diets or even better genetics, live longer and happier despite
their ailments, such as on the island of Ikaria, Greece (see Buettner, 2012). This
example and countless more provide proof that the combination of genetics
and the environment play a role in successful ageing, hence the lifelong debate
of nature versus nurture (Boyd and Bee, 2012). Perhaps they were thinking of
Odysseus’ journey and his return as an older man to his island of Ithaca, as the
EU has an ‘ITHACA’ project with nine European Regions on healthy ageing,
to share experiences and ‘good practices on smart health and care innovation,
with the aim to improve active and healthy ageing of the population’ (see www.
healthyageing.eu/projects, para 1).

If researchers address the possible ‘divide’ in education on health literacy
(Kickbusch, 2001), calling for increasing our education for improved health
literacy in schools (Marks, 2009, 2012; McGovern, 2010; see also Chapters
2 and 34, this volume), then why not advocate for better understanding of
generational issues and basic developmental tasks of older people as a way to
improve relations and mitigate health outcomes? Granted, for many countries,
there is no systematised way of doing things, and it seems that younger people are
aware they need more general health education for both communicable and non-
communicable diseases, including nutrition issues (Vardavas et al, 2009). The field
of developmental science currently integrates genetic aspects, neuropsychology,
neuroanatomy and clinical psychology in addressing developmental groups; and
educational institutions have specialties in ‘applied developmental psychology’ where besides research and interventions, practitioners, organisations and political decision-makers are provided with fundamental knowledge with an emphasis on ‘prevention’ for such areas of child development, family and health (Freie Universität Berlin, nd).

Typical health issues resulting from the natural ageing process include loss of biological functions such as sight, hearing, possible dementia or loss of working memory and what are termed ‘cognitive challenges’, as well as an overall decrease in reflexes which, in turn, can affect behaviours (Baltes et al, 1999; Boyd and Bee, 2012; Chesser et al, 2016). These changes should keep us in tune with our policies, in re-evaluating our procedures for how to handle such issues as having an elder re-take a driver’s licence exam after a certain age, particularly if there was any documented careless driving, even for the Queen of England herself (Epstein, 2015). Social and personality development issues in the older years focus more closely at activity, disengagement and overall maintenance of one’s health. The importance of trust in the healthcare profession and better communication practices in the delivery of health information for many diseases, including chronic diseases more common in older age, are the topics of several articles and books (Schillinger et al, 2003; Taylor, 2009; Candlin and Crichton, 2013; van Wert, 2017). Issues leading to distrust of the system, where medical personnel are overworked, often making medical mistakes that prove fatal to patients and particularly older population groups, need to be continuously addressed in communities at large (Dunbar et al, 2011).

Positively, on the psycho-social side, multiple studies prove that those who have better coping skills, have strong religious beliefs or spiritual orientation, actively use their support systems and receive support towards maintaining their health or dealing with a chronic health issue like diabetes (for example, via self-management) have better health outcomes (Schillinger et al, 2003; Taylor, 2009; Boyd and Bee, 2012). Rowe and Kahn (1998) indicate that the ‘successful ageing paradigm’ has three components including good physical health, retention of cognitive abilities, and continuing engagement in social and productive activities, and another aspect of successful ageing is a subjective sense of life satisfaction. Although some have criticised this paradigm as leading to potential ageist stereotypes, the overall view is that for gerontological research the paradigm has broadened how the latter study old age (Boyd and Bee, 2012). Could this not be enhanced if people have higher health education and higher literacy? We can certainly glean that these people, regardless of culture or socioeconomic orientation, likely have a more positive health literacy baseline.

Notably, the constant strive, or some would say ‘need for evidence’ particularly showcased in US culture (Chesser et al, 2016), may miss aspects of a more holistic approach to dealing with disease-related issues, where there are possible ‘grey zones’, especially in issues of trust-building between individual healthcare providers and their patients (Candlin and Crichton, 2013). There are clear advantages to improving health literacy both on the communication and decision-
making front that include cost savings and improving the satisfaction of patients and providers (Chesser et al, 2016). However, as medical journalist Lynn Payer emphasised in her book *Medicine and culture*, we need to examine our approach, the language we use and perhaps medical aggressiveness in how we diagnose, treat or prevent illness as ‘taking something out rather than adding something to increase the resistance’ (Payer, 1996, p 127), and how ‘scientific’ medicine takes over the rather ‘unscientific’ desires of the patient (1996, p 155).

When thinking about developing materials that are easy-to-read and that can relate to the ageing population, we need to think about pragmatics and text theory, which come from the field of sociolinguists. Zarcadoolas’ (2011) article on ‘the simplicity complex’ calls for simplifying the language of health communication and health promotion materials as the challenge of the 21st century, referring to low literacy as the ‘silent killer’. She refers to plain language theory and the history of functional literacy tests as well as readability, which was more popular in the US in the 1950s and 1960s, as gross screening tools. Although language may be simplified, this does not mean that the end user can ‘decode’ the message correctly to understand what action they need to take for their health; researchers need to integrate knowledge from the fields of health communication, linguistics, social psychology and adult education, among others, in a dialogue about health literacy, in discussing how new media and human factors engineering can contribute, as well as practical application for communicators (Zarcadoolas, 2011). Those with diverse health literacy apparently process text and picture passages about self-care topics differently, as a study on older adults with hypertension revealed (D’Andrea, 2010). Although a small sample of 41 older adults in a community in Illinois, US, this study found that health literacy was related to the total time spent during the first read of text, and at the points of processing the higher knowledge, individuals (with higher health literacy) were better able to differentiate between relevant and irrelevant pictorial information; the researcher indicated that this may be useful in the design of multimedia documents for this target population (D’Andrea, 2010). Past studies have focused on the importance of readability and access of printed material such as health pamphlets distributed to patients in hospitals and health centres (Kondilis et al, 2010). Furthermore, easy-to-read health information for consumers of special groups such as those on Medicaid (Root and Stableford, 1998) confirm that older people have lower health literacy as compared to younger people (Rudd, 2007).

The internet is becoming increasingly popular as a source of health information, and large-scale datasets from sources like Eurobarometer track usage – when comparing several European countries those in Northern Europe use the internet as an important mass media source of health information while this is less common in Southern European countries, although the use of the internet for health information is clearly now on the rise (Kummervold and Wynn, 2012). E-systems can help personalise patient records as a way to help doctors both track and communicate better with their patient’s part of the ‘patient-centred’
movement (Krist and Woolf, 2011). Furthermore, more advanced systems look at organisation-wide changes for improving healthcare settings and systems oriented for more effective interventions or treatment, such as having shared medical appointments/group visits for helping those with chronic diseases like diabetes better manage their conditions (Krish et al, 2008), since we know older people tend to be more ‘forgetful’ special attention will be particularly helpful to this group.

Osborne (2005) provides strategies and suggestions that evolve around better communication of messages to several categories of patients including special groups like those who are deaf and hard of hearing, promoting Health Literacy Month (in October), which addresses several issues including risk communication, the internet, using short stories and narratives to better communicate with patients. This is validated by van Wert (2017), who discusses the importance of storytelling with elder patients whose families are both trying to find appropriate treatment and alternatives, seeking options for care such as palliative care consultation, and generally navigating the healthcare system during illness and the end-of-life stage. Looking to the family as a way to assess the patient’s health literacy abilities as well as decision-making and developing and adapting transition planning tools as part of the Transitional Care Model were presented in Nishita and Browne’s (2013) paper, which are useful for those experiencing caregiver burden and/or a high number of hospitalisations. Furthermore, if we were called to teach health literacy in school health promotion starting with the new millennium (Peterson et al, 2001) and beyond (McGovern, 2010), we also have a responsibility to promote health literacy to all levels of caretakers and healthcare providers working with families and their older clients and patients.

A married woman in her early forties, discussing her ageing parents, commented:

‘Both sets of our parents on both sides have many chronic health problems. They don’t “listen” necessarily to what their children tell them, I think they are fighting the idea of getting old … their doctors confuse them with too much information about their medication. How can they remember everything? We can’t even do it and we are younger! They often forget since their mind does not work the same as when they were younger … they have complicated treatment issues, they have to think of things like their diet and medication, and if they don’t have caretakers like us, they don’t do well and everyone suffers. I wish that healthcare professionals would figure this out … my father fell and hurt himself because he doesn’t want to wear his glasses. He didn’t see where he was going on a sidewalk [pavement] which had many potholes. My mother-in-law fell last week and did not want to tell us to not get us upset, and she doesn’t have support and lives far from us in a rural area. It’s hard.’ (personal communication with M. Gerakoulakou, 17 December 2017)
Death, dying, grief and bereavement

If you bring up the concept of ‘death’, you may be met with stares and often superstitions, even fear in bringing the issue up, but this is an inevitable part of life. Dealing with loss is not a new phenomenon in research; grief is a normal emotional response to loss and death, and this feeling, along with others, can be intensified with the death of a loved one. Kübler-Ross (1969), in her initial work with cancer patients, suggested that loss and grief counselling is a field in clinical psychology that deals with helping individuals cope with the emotional pain in order to return to their normal development. The therapy techniques mostly focus on helping people understand the normal stages of the grieving process, and provide them with the necessary support while they go through mourning. Kübler-Ross (1969) suggested the ‘five stages of the grief cycle’, including denial, anger, bargaining, depression and acceptance, although a person may not go through these stages in this order. Other thanatologists (those who study issues related to death) have created similar stages and also bring up the issue of pathological grief, a set of depression-like symptoms following the death of a loved one for more than a period of two months, which some call ‘post-trauma’ (Gerrish et al, 2009). The recommendation is to diagnose and treat this condition to prevent additional mental and physical health issues, including long-term depression or even suicide, particularly for widows/widowers (Boyd and Bee, 2012). The issue of coping is of particular concern for younger people including adolescents, since researchers indicate that coping may be more difficult for them, and may have a significant lasting disruption if it is not dealt with adequately – the selective memory of events associated with loss and management of memories may prevent one’s normal development stage (Jacobs et al, 2000).

One cannot overlook the idea of cultural traditions and rituals as ways to support those individuals and groups better cope through the grief cycle. Cultural traditions involve rituals; this is generally defined as repetitive social practices, which differs from typical daily routines. There is a type of ritual schema that often have roots in myth and religion, although some rituals such as birthday parties are not religious in nature but very much part of a cultural norm (Schultz and Lavenda, 2009). Various cultures around the world still practise rituals that involve ancestor worship and may even involve sacrifice (usually of an animal), elaborate burial ceremonies and the preparation of specific food dishes – these hands-on practices are called ‘mourning rituals’ and some transcend through ancient times (Schultz and Lavenda, 2009).

Furthermore, the physical burial space reflects the religious and cultural traditions of the times, with respective statues, symbols and physical material such as marble or stone used for grave markers or ‘tombstones’ in cemeteries throughout the world. Cemetery records and headstone inscriptions are sources of birth and death information for future generations, and also for historical records of how death was recorded (see www.ancestry.com/wiki/index.php/Cemetery_Records). The images that follow include traditions from ancient to modern Greece, and colonial times in the US (see Figures 41.1, 41.2, 41.3).
Figure 41.1: Ancient female mourners, Crete, Greece (Archaeological Museum of Chania, Crete)

Source: Photograph taken by B. Kondilis (2016)

Figure 41.2: Ioannis Poulakos family grave, Laconia, Greece

Source: Photograph taken by B. Kondilis (2017)
Interestingly, some artefacts place more emphasis on the cause of death (colonial Lexington), others on the emotional consequence of death (the mourners of Crete), while others are familial personal images or religious cultural symbols.

Transitional care is gaining more attention in research literature, as it relates to specific cultures and elders and making healthcare decisions (Nishita and Browne, 2013). This may involve getting support both within and outside the home, and for those who have long-term dehabilitating or terminal illness it may be necessary to prepare the family and caretakers for potential loss (Boyd and Bee, 2012). Furthermore, caretakers may suffer from potential burn-out, referred to as ‘caretaker burden’, if these individuals are not doing enough self-care; it is likely, for example, for those elders who lose a spouse to suffer themselves from an illness as their immune system may be compromised – the first two years are critical after a loved one’s passing (Boyd and Bee, 2012). Understanding the stages of death, preparing for death if possible, may allow people to handle end of life in a more ‘health-literate’ way. A counselling psychologist who has been working for over five years with clients on issues related to loss indicated, ‘when there is some knowledge about death and dying the therapy is shorter and is more effective … the goal is to get the client reconnected with life…. The building of trust is a fundamental major part of the counselling process’ (personal communication with A. Sgourou, 15 December, 2017).

Addressing the life cycle and related issues should be part of our formal and informal education. This knowledge and planning for action can better support caretakers, families and communities who are dealing with both cross-generational and intercultural issues, since advancing health literacy at the micro and macro level is a benefit for us all.

Figure 41.3: Lexington Cemetery, Lexington, Massachusetts, United States

Source: Photograph taken by B. Kondilis (2017)
Discussion

The need for continued work regarding health literacy is clear, as is the long-term goal for healthier and better functioning societies, particularly for older individuals whose physical and mental functioning are at a natural decline, for those who have chronic health issues, who are marginalised, or who may have socioeconomic disadvantages. The need to emphasise cultural strengths is always a positive, and ‘culture’ can be defined by context and thinking about the health frames including the language we use. In turn these frames affect how we see ageing as a normative process and our need to evaluate any relevant policies or procedures and reinforce our individual and community education or re-evaluate policy. Caretakers and family members, community members, are natural resources for healthcare providers to tap into, focusing on patient-centred approaches, and looking to transitional care as options for people and their loved ones.

Patients/clients and their family/caretakers can benefit from increasing their own health knowledge base, obtaining the support that is available to them, whether real or virtual from the online world, including any professionally trained people they may access. On the other hand, healthcare providers, educators and other related administrators must keep up with health education efforts (disease prevention and health promotion) for all ages and at all societal levels, not excluding policy. Non-governmental organisations in countries can be of particular help to both economically disadvantaged and other marginalised groups in accessing care, working on chronic health issues, building networks for better collaboration and highlighting community strengths.

Keeping positive short and long-term outcomes in mind is part of our investment in building and assessing health literacy. Notably, both a physical and philosophical long-term ‘investment’ benefits everyone involved. The strengthening of social capital at individual or group level, regardless of current economic situation or country of origin, can seemingly improve health literacy for better outcomes. This will, in turn, positively affect both caretakers and future generations.

Conclusion

The ageing process as well as intergenerational issues on the inevitable stage of the end of life go hand-in-hand with related sociocultural practices and ramifications, as societies continue work on building and supporting health literacy across the lifespan. The role of the caretaker, whether in private or public settings, individual or collective, online or face-to-face, in helping people access information and care, as they transition to end of life, is key. This chapter has addressed some of the issues involved with older individuals whose physical and mental functioning are at a natural decline, in particular for those with chronic health issues, those who are marginalised or those with socioeconomic disadvantages.

Health literacy is not only a focus on the individual, but also at the social or community level. We cannot deny that the elderly benefit all societies by sharing
their knowledge and experience, and in turn they also benefit from a more open, supportive and well-functioning society. Thus, the interplay of the micro- and macro-levels, continued support for health promotion and disease prevention, the constant strive for improving patient–provider relations, building networks in social capital, infrastructure and re-examining policy, these can all work towards enhancing health literacy across the lifespan.

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