Commentary

Commentary on Mancuso JM. Assessment and measurement of health literacy: An integrative review of the literature. Nursing and Health Sciences 2009; 11: 77–89

I congratulate Dr Mancuso on the detail and presentation of information in her review article that was published in Nursing & Health Sciences last year. Her review was personally timely, given that I too was gathering this information for my own doctoral research on health literacy at the University of Tasmania, Australia. That said, I wish to make some additional comments that are based on my review of the relevant literature.

First, to Mancuso’s Table 1, I would add the Basic English Literacy Test (Downey & Zun, 2007), the functional, communicative, and critical health literacy scales of Ishikawa et al. (2008), and the more recent Medical Term Recognition Test (Rawson et al., 2009).

Second, under the heading “Implications and Recommendations”, Mancuso raises four constraints to the assessment of health literacy. To these, I would add the disparate nature of the abilities and constructs that the available tools measure (Chew et al., 2008; Barber et al., 2009), despite the apparent uniformity alluded to in the article, with their collective focus on medical terms and materials in the clinical context. Likewise, the tests do little to define aetiologies or direct care management (Davis et al., 2005; Jeppesen et al., 2009). They focus predominantly on reading and writing to the detriment of oral, aural, and visual competencies (Rudd et al., 2004; Rootman & Ronson, 2005; Buchbinder et al., 2006; Nutbeam, 2008; 2009). Hartley and Horne (2006) comment on the need for health literacy tests to be validated in other cultures and social contexts, which is highlighted by the point-of-note that Mancuso makes early in her article that “tools specific to the assessment and measurement of health literacy in the medical setting were lacking in Europe, Canada, Australia, and other countries” (p. 78). Finally, additional assessment constraints are the lack of an underpinning theory of health literacy (Pleasant, 2008) and a consensual definition (Baker, 2006), both of which add to the vagaries of the current measures and, in terms of the latter, a point that Mancuso rightly suggests is an issue for future research.

Third, under the same, aforementioned heading, the question of the contextual specificity of an ideal measure is raised. That is, should such a measure assess reading, comprehension, and numeracy in a general sense? Or should it pertain to a diagnosis-specific population, of which the literacy assessment tool of Nath et al. (2001) for people with diabetes is but one example? Currently, it could be argued that health literacy is too broadly defined to realistically allow a single, all-encompassing measure that could be used by researchers and clinicians alike. That said, there is merit in both a general and a specific tool, the latter perhaps a derivative of the former. Importantly, according to Pleasant (2008), efforts toward the development of a comprehensive measure of health literacy would necessarily give consideration to, and be built upon, an empirically generated theory, be multidimensional in content and methodology to reflect a universally defined scope of health literacy, allow its use in a variety of cultural, life stage, population group, and research contexts, ensuring the comparability of data, and be adaptable to guarantee its longevity. A challenging demand perhaps, but “these are not totally new challenges in the social sciences” (Nutbeam, 2008: 2076). Certainly, the current measures of health literacy have made resourceful in-roads.

Fourth, in her concluding remarks, Mancuso advocates health literacy screening in terms of promoting the field, clinical application, and enhancing quality of life through improved health outcomes. Support in the literature for this viewpoint is considerable (e.g. Chew et al., 2004; Shohet, 2004; Dani et al., 2007). However, it is not a viewpoint that is shared by all. For example, Paasche-Orlow and Wolf (2007: 100) refer to a noted potential for shame and alienation, caused through clinical screening, as “fair evidence to suggest that possible harm outweighs any current benefits; therefore clinical screening for literacy should not be recommended at this time.” If the discourse that is occurring on the Health and Literacy Discussion List of the US National Institute for Health and Literacy (http://www.nifl.gov/mailman/listinfo/HealthLiteracy) is any indication, then this debate continues and Mancuso has certainly made an informative contribution, for which I am grateful.

REFERENCES


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