COMMENTARY

Oral health literacy: correcting the mismatch

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Any unnecessary death and most especially the death of a child in an industrialized society such as ours with the means to prevent the cause of death, to intervene early, and treat even late symptoms, is not simply tragic but criminal. Horowitz and Kleinman insist that we learn from the untimely death of Deamonte Driver and take action.

Horowitz and Kleinman review steps being taken in Maryland and suggest that attention to health literacy – and, in this important case, to oral health literacy, will enable us to avoid such events and serve to reduce health disparities in the future. They rightly point to the accumulated evidence that close to a majority of US adults have limited literacy skills and that a substantial body of research indicates that those with poor literacy skills are likely to experience untoward health outcomes. We know, for example, that those with limited literacy are less likely to engage in preventive action, to engage in screening and treatment, and to manage a chronic disease well. The publication of findings from the adult literacy surveys conducted first in 1992 and again in 2003 spurred this interest in the possible health effects of the poor literacy skills.

However, educators remind us that literacy does not exist in a vacuum. For example, assessments of reading skills must also consider the difficulty of the text; similarly, measures of listening skills must appraise the spoken word and its delivery. Thus, we cannot assess people's ability to access oral health information if the messages are not provided or filled with jargon. We cannot assess someone's reading skills based on health materials that are poorly written. Attention cannot be entirely focused on the skills or deficits of the public. Instead, we must focus attention on the abilities of health and social service professionals to communicate with the public, to identify and remove literacy-related barriers to information, decision making, and healthful action. Furthermore, we must change those features of our health systems that hinder access to information and care.

Horowitz and Kleinman avoid the errors perpetuated in the early health literacy studies and editorials that evidenced a somewhat myopic focus on deficits of patients. In contrast, Horowitz and Kleinman correctly point out that action must also be taken to enhance the oral health literacy and communication skills of professionals. They note that the 2007 Maryland Dental Action Committee Report calls for educating parents, caregivers, and health professionals about oral health. Horowitz and Kleinman are establishing baseline data of knowledge and understanding, practices and techniques, and skills of the lay public, as well as of social service and health professionals. In so doing, they present a balanced approach for oral health literacy that practitioners and policy makers must emulate.

We need to pay attention to the mismatch between what we now know are average literacy skills of US adults and the burdensome demands of messages, directions, and information that are not easily understood or accessible.

Conflict of interest

The author declares no conflict of interest.

Commentary on "Oral health literacy: a pathway to reducing oral health disparities in Maryland"

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The widening gap between the literacy skills of the public and the oral health information demands that are placed on them is a major public health problem. A number of fundamental issues need to be considered in the implementation of a statewide oral health literacy campaign to address this growing gap.

First, health literacy is grounded in two disciplines – clinical care and public health – which affect selection of intervention strategies (1). The field has been shaped largely by a body of literature that considers health literacy as an individual risk factor for poor oral health outcomes. Hundreds of studies have shown an association between low literacy skills and poor health outcomes, including oral health. This view of health literacy has led to defining it largely as a deficit in the public's ability to access and use health information. It follows from this view of health literacy that the focus of interventions should be mostly on conveying information in a way that can be understood by the public. We therefore strive to communicate in plain language and use other techniques that reduce literacy demands on the public.

The other view considers health literacy as an asset, or a resource much like social capital, that the public has at its disposal to promote health. This population perspective leads to an emphasis on interventions that target the public's ability to better manage their own health and requires strategies involving areas such as public education. Comprehensive approaches to oral health literacy will necessarily need to consider both perspectives (2).

Second, any statewide approach needs to consider multifaceted interventions that are implemented through collaborations with multiple partners. The Maryland Initiative is appropriately focused on the oral health of young children. More than 21 million (29 percent) parents in the United States have limited health literacy skills, which can put their children's oral health at risk (3). These families have multiple contacts with many different types of child professionals in their communities who can provide oral health information. The goal of public health should be to integrate oral health information into all aspects of families' formal and informal social networks. It also follows from the first point that successful strategies to promote health literacy in dentistry will need to be developed in concert with broader efforts to improve basic literacy skills of the population. The Maryland Initiative recognizes the need to take a broad population-based strategy and involve multiple partners, but the task is nevertheless daunting, particularly because comprehensive models for implementing a successful statewide oral health initiative have not been tested.

A third point relates to the oral health messages themselves and how they are delivered. A first step in any information campaign is to agree on what parents need to know and what they will be asked to do. Control of pediatric dental caries requires relatively simple behaviors on the part of parents, but it is often difficult to keep the messages simple. They need to be evidence based, appropriate for the targeted audience, consistent with and supported by policies and regulations, and limited in number. Uniform messages that permeate families' information networks are essential to ensure that they have multiple exposures to consistent messages.

Fourth, the information should be provided using methods that will result in targeted behavior changes. The Community Preventive Services Task Force recommends a number of health communication and social marketing strategies based on evidence of effectiveness, but most involve multiple strategies and are often connected to the distribution of free or reduced cost products such as child car seats (4). None involve oral health. Research suggests that health and child care providers will need training in how to counsel parents in a patient-centered way in order to achieve desired behavioral outcomes. Promising methods are being evaluated (5).

Maryland is to be congratulated for undertaking an ambitious agenda in oral health, particularly one that includes strategies to address the oral health information needs of its residents. Literacy skills are thought to be important determinants of oral health disparities, suggesting that attention needs to be given to literacy if national oral health goals are to

be achieved. The role of health literacy in dentistry is evolving, which leads to a final point. As the field grows, states will have the opportunity to contribute to evidence about best practices for oral health literacy interventions. Basic research in oral health literacy is clearly needed, but while this research is being conducted, demonstration programs should proceed in one-on-one parent education, mass communication, and core public health functions like surveillance of population-level oral health literacy. This recommendation requires that dental public health formally evaluate its experiences and share results with colleagues.

Conflict of interest

The author declares no conflict of interest.

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