http://doi.org/10.35847/CLarrotta.7.2.50

Forum: English Language Learners and Health Literacy

(Part 3 of 3)

Health Literacy Access: A Shared Responsibility

Clarena Larrotta, Texas State University

Access to health literacy does not just mean obtaining and retrieving information but the ability to acquire that information in ways that make sense to the patient, in this case the adult English language learner (ELL). Santos does an excellent job of presenting the issue of the good patient and the good language learner, my effort here will be to amplify and expand on some of her points.

Health literacy access also involves understanding health literacy resources and how to use them (Shashikiran et al., 2023). Specific skills are required to obtain, understand, and use health information through verbal communication, not just through written materials (Muscat et al., 2017). In other words, ELL patients should possess functional health literacy skills (e.g., basic oral skills), communicative health literacy skills (e.g., advanced skills to extract information about options, benefits, and harm), and critical health literacy skills (e.g., critical skills to reflect on information such as being able to integrate knowledge with personal preferences to make informed decisions) to be able to have full access to health literacy (Muscat et al., 2017). Considering this broader view of what health literacy access entails will add to the discussion regarding the interconnected nature between the good learner, the good patient, and language as presented by Santos (2025). Specifically, the present article focuses on discussing shared responsibility to acknowledge the distinct and complementary roles that adult education programs, adult educators, ELL patients, health organizations, and health professionals have in making health literacy access successful.

As stated by the Centers for Disease Control and Prevention (CDC), the 2020 definition of health literacy encompasses personal and organizational levels of involvement. *Personal health literacy* is defined as the "degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others" (CDC, 2024, n.p.). In contrast, *organizational health literacy* is the "degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others" (CDC, 2024, n.p.). This updated definition acknowledges the need for shared responsibility from part of the ELL patient and the health care system (health organizations and professionals). Furthermore, this definition of health literacy emphasizes "the individual's ability to use health information rather than just understand it, while acknowledging that organizations also have a responsibility to actively address health literacy" (English, 2022, p. 101). Health organizations have a responsibility to address health literacy and health equity, "the attainment of the highest level of health for all people, so that everyone has the opportunity to be as healthy as possible" (CDC, 2024, n.p.). The following paragraphs present a brief overview of how adult education programs, ELL patients, health organizations, and health professionals can work together and contribute to making health literacy access a real possibility.

Regarding the responsibilities of the ELL patient, it is expected that they stay informed, be critical, and keep up with technology. However, to master these skills, ELLs should be able to participate in health literacy instruction that equips them with the strategies and skills required to succeed in modern times (e.g., high level communication skills, computer skills, digital literacy knowledge, telehealth skills, skills for artificial intelligence usage, cybersecurity skills, etc.). There is a crucial need for creating up-to-date, federally funded, programs and curricula that support the development of adequate health literacy skills of adult ELLs. As an example, the Step One Curriculum for

Correspondence: larrotta@txstate.edu

older immigrants in Amherst, Massachusetts, provides access to beginning-level English language instruction that meets older learner needs (Weintraub, 2025). Similarly, the Health in the English Language course in Anchorage, Alaska, is an intervention program addressing health information, reporting medical conditions and symptoms, understanding health insurance, nutrition, mental health, first aid, dentistry, vaccinations, and medications (Shashikiran et al., 2023). Transferring best practices from these and similar health literacy programs designed for ELLs is crucial to be able to offer adult education opportunities that are relevant and ongoing throughout the United States.

Likewise, health organizations and health professionals should keep in mind "health literacy best practices" such as the "use of plain language, use of customer preferred language and communication channels, and use of cultural and linguistically appropriate language" (CDC, 2024, n.p.) when creating health literacy materials and when communicating with ELL patients. The language of health and medicine is complex and, in many ways, learning it is similar to learning a second language. As English (2022) suggests, health care providers must ensure that written materials (handouts, brochures, and web sites) do not create barriers for the many patients who have little to no background knowledge on health-related topics (p. 101). Health literacy best practices will benefit ELL patients and native English speakers equally. English (2022) addresses the importance of providing patient-centered care through using adequate interpersonal communication (ensuring patient comprehension), showing empathy (relating to the patient's situation and experiences), and practicing active listening. As English (2022) states, "health literacy skills are affected by age, education, income, health insurance status, and first language [English] acquisition" (p. 101). Health care organizations must become aware of the benefits and overarching need for easier access to health literacy. The health care experience is equally intimidating to all populations, older adults, individuals with disabilities, ELL patients, and native-English speakers.

It is crucial to promote different formats of communication and offer patient-centered care that goes beyond written health materials, as to include support for better verbal communication, technology, and telehealth usage. For example, in Australian adult education settings, Muscat et al. (2017) implemented a health literacy program for adults with low literacy levels to help them develop skills to talk to health care providers and share health decisions. Muscat and colleagues describe the range of health literacy skills needed for communication and decision-making and present a model in which verbal skills are an important part of health literacy. "This model positions 'listening' and 'speaking' as distinct health literacy skills for the verbal exchange between the patient and health professional" (Muscat et al., 2017, p. e258). In this view, the ELL patient should be aware of their right to contribute to the health care consultation and participate in decision making concerning their own treatment and care. As Muscat et al. (2017) state, this asset approach to health literacy "recognizes efforts to improve functional, communicative, and critical health literacy" (p. e259), integrates shared decision-making, and raises critical consciousness to overcome obstacles to good health. According to these researchers, program participants reported new appreciation of the right to participate in decision-making, increased assertiveness, and self-efficacy for health consultations. Muscat et al. (2017) recommend facilitating verbal skill development across the domains of functional, communicative, and critical health literacy, influencing ELLs' attitudes toward question-asking by positioning it as a consumer right, and presenting decision-making as a joint venture between patients and providers. Health literacy programs should adopt a similar approach empowering ELLs to be proactive patients who can discuss medical recommendations, critically reflect on the medical information and advice received, and participate in health care decision-making.

In a shared responsibility approach to health literacy, community health partnerships between universities and literacy programs are useful to promote experiential learning opportunities beneficial to both ELL patients and future health professionals. For instance, Gao et al. (2022), report on Health in the English Language, a partnership delivering two virtual health literacy courses to adult ELLs: "Pre-health undergraduates gain insight into the importance of communicating with and advocating for non-native English speakers" (Gao et al., 2022, p. 33). Based on a needs assessment conducted to design the program, the topics covered in the courses included going to the doctor, what to do in emergencies, healthy eating and exercise, medication safety and use, and health insurance. In addition, course activities included "student-led discussions, dialogues, vocabulary learning, practice questions such as reading medications or nutrition labels, writing activities, and games" (Gao et al., 2022, p. 35). The health literacy researchers found that although convenient, online teaching and learning posed challenges due to disparities in technology access. For example, having access to a computer did not mean that the learners had adequate digital literacy skills or were able to use basic software features such as typing in the chat when participating in the virtual class. Another important finding from Gao et al (2022) is that the learners participating in the health literacy courses had differing levels of understanding about the U.S. health care system and some did not even have insurance. In addition, they reported that the pre-health student-instructors learned about the importance of grasping the cultural dimension of health to best support non-native English speakers, communicate with them, provide a safe space, or advocate for them. The study by Gao et al. (2022) described the reciprocal nature and benefits of implementing community health partnerships.

To conclude, it is important to continue to explore the issue of shared responsibility further to make sure that ELL patients and native-English speakers are able to access health literacy regardless of their individual conditions (e.g., older adults, individuals with disabilities, ELL patients, and native-English speakers). Adult education programs, ELL patients, health organizations, and health professionals play important and complementary roles making health literacy access possible. Health organizations and health professionals should be mindful of incorporating health literacy best practices so as to not create extra access barriers for ELL patients and other vulnerable populations. More than ever, adult education programs and health organizations should work towards narrowing the digital literacy gap affecting marginalized populations. Modern times require the use of digital media platforms to find, evaluate, and communicate information, but this new approach can contribute to creating barriers to health literacy access. Likewise, critical health literacy should be nurtured in adult education programs to make sure that ELL patients behave as inquisitive health participants and informed consumers. There is a crucial need to create more programs and curricula focusing on health literacy and as part of the regular offerings in adult education programs. In addition, community health partnerships between universities and adult literacy programs should proliferate instead of being offered as sporadic research studies conducted by a handful of interested researchers. Achieving health literacy and health equity should be a goal and a shared responsibility.

References

Centers for Disease Control and Prevention (2024). *What is health literacy?* https://www.cdc.gov/health-literacy/php/about/?CDC_AAref_Val=https://www.cdc.gov/healthliteracy/learn/index.html

English, K. (2022). Guidance on providing patient-centered care. *Seminars in Hearing, 43*(2), 99-109. https://doi.org/10.1055/s-0042-1748834

Gao, A., Kuwahara, L., & Shaw, B. (2022). Best practices for health literacy education of English language learners. *Georgetown Scientific Research Journal, 3*(1), 32-43. https://doi.org//10.48091//gsr.v3i1.55

Muscat, D. M., Shepherd, H. L., Nutbeam, D., Morony, S., Smith, S. K., Dhillon, H. M., Trevenal, L., Hayen, A., Luxford, K., & McCaffery, K. (2017). Developing verbal health literacy with adult learners through training in shared decision-making. *HLRP: Health Literacy Research and Practice*, *1*(4), e257-e268. https://doi.org/10.3928/24748307-20171208-02

Shashikiran, S., Mendoza, J., Facklam, A., & Riley, J. B. (2023). Promoting health literacy among adult ELLs virtually during COVID-19. *Health Promotion Practice, 24*(3), 588-592. https://doi.org/10.1177/15248399221086871

Santos, M. G. (2025). Reflections on “good” language learners, “good” patients, and language. *Adult Literacy Education: The International Journal of Literacy, Language, and Numeracy*, 7(2), 39-44. http://doi.org/10.35847/MSantos.7.2.39

Weintraub, L. (2025). Grandma needs English, too. *Adult Literacy Education*, 7(1), 37-41. http://doi.org/10.35847/LWeintraub.7.1.37