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EDITORIAL

Health literacy in health practices: no longer prescriptive, but co-producers of care

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In view of growing efforts to produce knowledge in the scientific community and foster practices aimed at health literacy (HL), exemplified by the dissemination of knowledge through podcasts by the Brazilian Network of Health Literacy (https://rebrals.com.br/podcast/), health professionals, including nursing professionals, need to dare to adopt new ways of thinking based on logical evidence and ethical demands. The feasibility of HL innovations via the nursing profession in the Unified Health System has already been identified,[1]adding to evidence on the importance and efficacy of multiprofessional competencies and skills for the same purpose.[2]

With this emerging theoretical perspective, which adds complexity to our understanding of HL in both practice and research, the positivist perspective is abandoned,[3] and we are forced to acknowledge that it is necessary to go beyond mere classification and prescription for clients. This is in line with a conception of health education and literacy as an emancipatory practice and a liberating life experience in whatever form it occurs – individual, family, community, electronic, digital, etc. – when the following person/patient-centered practice and structure is implemented according to the following equation: clientele + health professionals + HL-responsive health organizations = better health literacy outcomes.

Currently, even with the increasing attention to person-centered care and patient-involvement in their own care, both at the political and practical levels, the literature has neglected the role and contribution of health services in carrying it out within the scope of HL. Most of the attention has focused on individuals' HL competencies to access, understand, and use health information to effectively navigate the health service system.[4] Since 2016, the WHO[5] has considered HL as a key social determinant of health (SDH) and not solely an isolated cognitive skill. As a SDH, HL impacts health outcomes, but it should not be treated as merely a fixed individual competency, but that the resources distributed and made available in an individual's social network should also be considered.[6]

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This new conceptual framing of HL has two main aspects: (a) the skills in accessing, understanding, evaluating, and using health information that users/communities acquire throughout their lives, and (b) the health services organization that makes services and information accessible so that clientele/communities can use to improve their health.[7] This perspective requires changes in exclusively prescriptive healthcare, a classic top-down approach, which has limited-to-no patient involvement, to making room for co-productive health practices with which health professionals/health services and clientele/communities collaborate in the care process.

Health co-production is defined as "the interdependent work of clients and professionals who are creating, designing, producing, delivering, evaluating, and reevaluating the relationships and actions that contribute to the health of individuals and populations."[8:2] It brings with it a new framework for delivering healthcare, based on the voices of users/communities, to improve the care they are receiving; that is, care is carried out with them and for them.

This co-production of knowledge for healthcare rejects the model of care delivery that is conducted solely by health professionals and which characterizes clientele/communities as mere recipients of care. Instead, this new model of understanding HL argues that clients can possess critical knowledge of their health circumstances and conditions. However, more often than not, this knowledge is not explored, limiting its role in the functioning of the health service system.[4] In this sense, health services should implement more effective and evidence-based strategies for clientele/communities and for the organizational context to promote more informed decision-making about health and promote a more personalized care experience. Health practices guided by the process of collaborative and participatory co-production generate both social and scientific results, contributing to the resolution of complex public health problems.[9]

In such context, individual HL and organizational HL are two essential requirements for the co-production of health services. The development of HL with the engagement of health professionals in involving clientele/communities in partnerships that value health co-production can result in greater quality, safety, and equity in care and collective learning, among other beneficial outcomes.[10] On the one hand, both services and professionals should: (a) develop a shared organizational view of HL; (b) work to incorporate concrete SL actions into organizational policies; (c) identify HL leaders who promote organizational commitments to meet the special information needs of users/communities at all levels of HL; and (d) engage health professionals in initiatives aimed at co-producing health services.[4]

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Therefore, the interaction between HL (individual/community and organizational) and the co-production of health services should be examined at the macro (health systems), meso (health services), and micro (client-professional relationships) levels, in order to implement an ecosystem of health services that feeds back into people's lives and the system itself – the more engaged clientele /communities are, the greater their contribution to ensuring that the health systems that serve them are most effective.

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