

# Health Literacy 2015 Population Survey

## Summary



Study commissioned by the Swiss Federal Office of Public Health FOPH, Health Strategies Division

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# The key points in brief

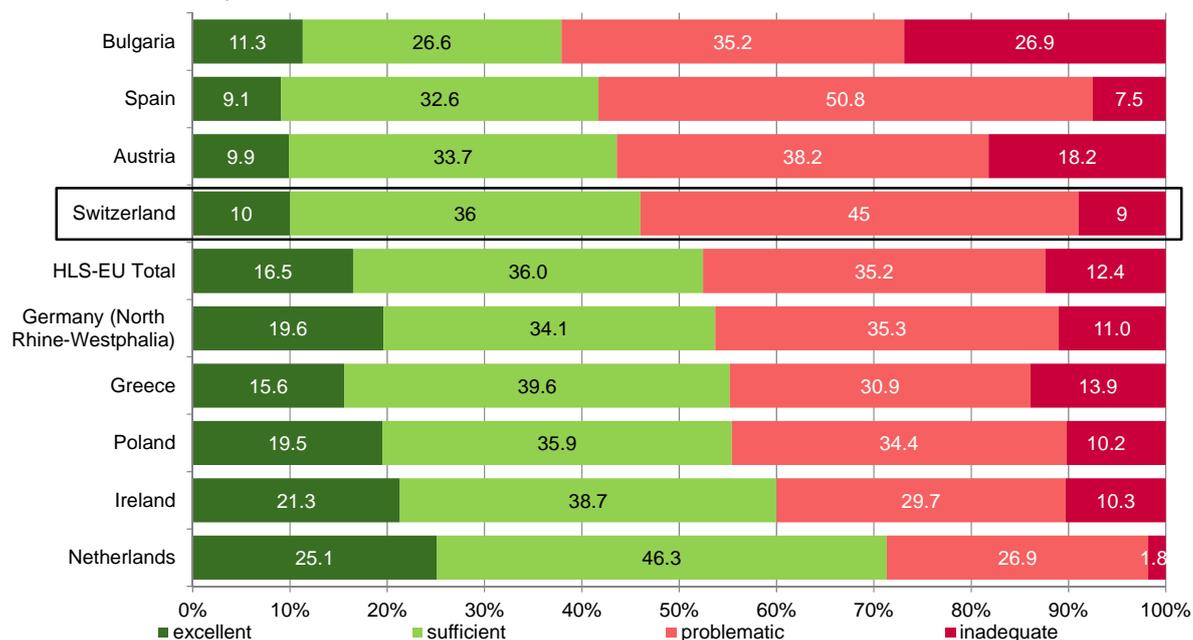
## What is the extent of the problem of limited health literacy in Switzerland?

The problem of insufficient health literacy in Switzerland is **broad but not deep**. Broad means that in Switzerland a relatively large number of residents (as defined by the HLS-EU survey) have problematic health literacy (45%). Problematic health literacy is a more frequent occurrence in Switzerland than in most HLS-EU countries.

Graphic 1

## General Health Literacy Levels Threshold for Countries

in % of residents in Europe



Health Literacy Switzerland 2015, November 2015 (N = 1107)

Index consisting of 47 individual items, cf. chapter 3.1.2 in the final report; "HLS-EU Total" consists of the results of the eight EU countries in equal parts; the Swiss results are not part of the HLS-EU survey

At the same time, however, the problem is not particularly deep: less than one-tenth (9%) display inadequate health literacy. This means there are only a few negative extremes – but only relatively few positive extremes too. Ten per cent have excellent health literacy and 36 per cent adequate health literacy. It follows that a large part of the population is situated at the border between problematic and sufficient health literacy.

## Where do the greatest problems regarding health literacy lie?

Compared with the HLS-EU countries, there are greater problems in Switzerland when it comes to **assessing** and **understanding** information about **disease prevention**. Especially with regard to vaccinations – assessing what vaccinations are necessary (50% very or fairly difficult), understanding why vaccinations are necessary (32%), and deciding to have a flu vaccination (40%) – the Swiss respondents indicate more difficulties than their European counterparts.

Furthermore, in absolute terms they find it more difficult to assess the advantages and disadvantages of treatment options (44% very or fairly difficult) and whether a second opinion should be obtained (35%). They also have difficulty understanding the information on food packaging (37%), assessing the trustworthiness of information about diseases or health risks in the media (39%)

each), finding information about the health implications of policy changes (47%) or about the health promoting effects of their living environment (35%), deciding how to protect themselves against diseases on the basis of media information (31%), and judging what medical check-ups to undergo or the effects of the living environment on health and well-being (30% each).

Swiss residents have the fewest problems when it comes to following the instructions of doctors and pharmacists (10%), understanding instructions on how to take medicines (10%) and following them (11%), calling an ambulance in an emergency (10%), and finding information about support options with regard to unhealthy behaviour or information about health-promoting behaviour (12% each).

### **Which groups are particularly affected by inadequate health literacy?**

The strongest driver of low health literacy is **financial deprivation**. People who have difficulties finding the money to pay their bills in general, pay medical bills or pay for medication have lower health literacy. Financial deprivation – especially in comparison with the EU results – is a strong driver of poor health.

There is a clear connection between health literacy and **exercise**: individuals who rarely or never exercise have lower health literacy. Individuals with supplementary outpatient insurance on average have higher health literacy than those without. In both these cases, health literacy can be the cause or the effect.

The effect of social status on health literacy is not clear: if social status as stated by the respondents themselves is taken as a basis, then individuals with high social status have lower health literacy – which contradicts the results of the HLS-EU survey. If social status is worked out on the basis of income and education, the correlation is reversed: high social status means high health literacy. It seems that in the Swiss context, self-assessed social status does not measure the same thing as in Europe.

There are further, weaker influencing factors: with increasing age, people tend to have lower health literacy. The proportion of individuals with inadequate health literacy in particular is highest in the oldest cohort. Many middle-aged individuals, meanwhile, have problematic health literacy. As the level of education increases, health literacy tends to increase as well, and on average women have higher health literacy than men.

Finally, a migrant background, all else being equal, has only a weak bivariate influence on health literacy. Other variables such as financial deprivation clearly outweigh the effect. Migrant background alone is too general a category, as demonstrated by the additional subsamples: on average, Portuguese residents in Switzerland have the same level of health literacy as the population as a whole. In contrast, Turkish residents in Switzerland have a higher proportion of problematic or inadequate health literacy. Even if socio-economic and demographic control variables are taken into account, a small difference remains between Turkish residents and the population in general.

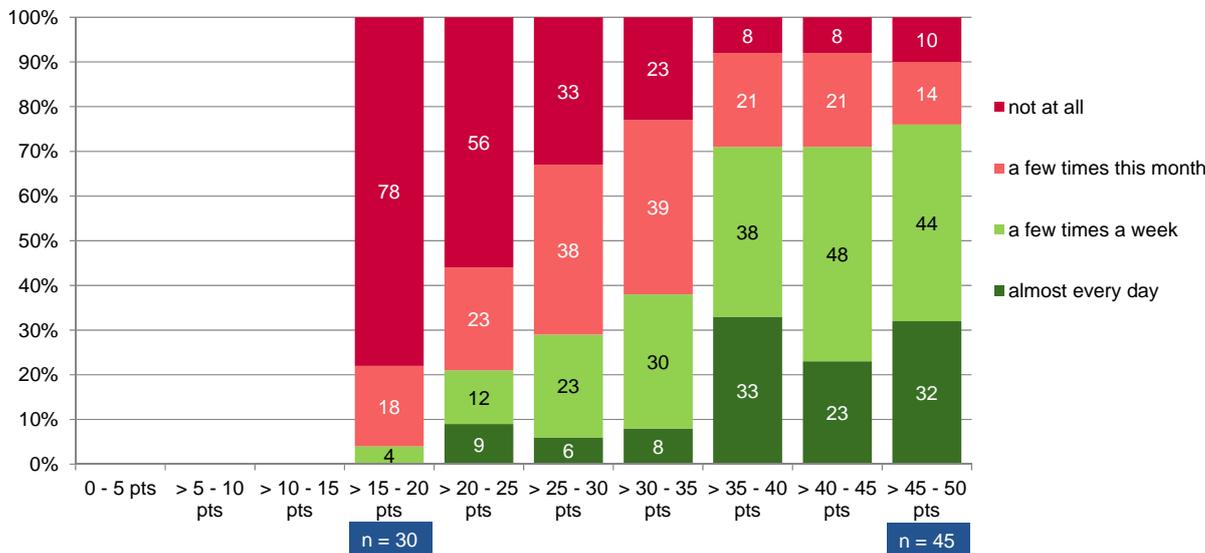
The differences regarding general health literacy within the Portuguese sample are largely explained by exercise (or alternatively age) and the gender of the respondent. In the Turkish sample, age is the most important predictor of general health literacy.

Graphic 2

## Physical Exercise by General Health Literacy Index in Switzerland

"How often during the last month did you exercise for 30 minutes or longer, e.g. running, walking, cycling?"

in % of residents in Switzerland



Health Literacy Switzerland 2015, November 2015 (N = 1107), sig.

Individuals with lower health literacy get significantly less exercise than individuals with higher health literacy. This is the strongest bivariate relationship between a health-related question and health literacy – stronger than in all the countries examined by the HLS-EU survey. No conclusive answer can be given as to what the cause and what the effect is.

Individuals with lower health literacy consider the state of their health to be poorer. Even controlling for other variables such as financial deprivation, exercise, long-term illness and age, this effect is measurable. The same is true for Portuguese residents. Among Turkish residents, state of health does not significantly differ with health literacy. The state of health of Portuguese residents above all, but also of Turkish residents, is poorer than that of the population as a whole.

Individuals with lower health literacy tend to have a higher likelihood of suffering from one or more long-term illnesses. Where this is the case, respondents with lower health literacy feel more limited by their health problems.

The lower an individual's health literacy, the more likely he or she is to have been hospitalised in the past or to have used the emergency services; in a multivariate regression model and taking into account all control variables, the latter is not significant. There is no bivariate correlation, however, with the number of visits to the doctor or the use of other medical services – in the multivariate case, the number of visits to the doctor tends to increase with increasing health literacy.

Individuals with low health literacy are more likely to be smokers. The same does not, however, apply to alcohol consumption, which tends to be lower with lower health literacy – which was also reflected in the HLS-EU survey. In the Turkish subsample, alcohol consumption is lower, while the percentage of smokers is higher than among the general population.

## Data pool

The results of the Health Literacy in Switzerland 2015 survey are based on a representative survey carried out by gfs.bern of 1107 members of the Swiss population aged 15 and above. As additional samples, 255 Portuguese and 250 Turkish residents aged 15 and above from all parts of Switzerland were questioned. The survey was conducted between 20 October and 12 December 2015 using CAPI interviews (Computer Assisted Personal Interviews). The sample was drawn from the sample register of the BFS. All test subjects were contacted in advance by letter and by phone.

Table 1

## Sampling errors

### Selected statistical sampling errors by sample size and base distribution

Sample size	Error rate base distribution	
	50% to 50%	20% to 80%
N = 1100	± 3.0 percentage points	± 2.4 percentage points
N = 1000	± 3.2 percentage points	± 2.5 percentage points
N = 600	± 4.1 percentage points	± 3.3 percentage points
N = 250	± 6.3 percentage points	± 5.1 percentage points
N = 100	± 10.0 percentage points	± 8.1 percentage points
N = 50	± 14.0 percentage points	± 11.5 percentage points

Legend: given a round number of 1000 respondents and a stated value of 50 per cent, the real value is between 50 per cent ± 3.2 percentage points, given a base value of 20 per cent between 20 per cent ± 2.5 percentage points. In survey research, a confidence level of 95 per cent is usually assumed; this means that a probability of error of 5 per cent is accepted that the documented statistical correlation does not exist in the population.

# Appendix

## **gfs.bern team**



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