

BMJ Open

BMJ Open is committed to open peer review. As part of this commitment we make the peer review history of every article we publish publicly available.

When an article is published we post the peer reviewers' comments and the authors' responses online. We also post the versions of the paper that were used during peer review. These are the versions that the peer review comments apply to.

The versions of the paper that follow are the versions that were submitted during the peer review process. They are not the versions of record or the final published versions. They should not be cited or distributed as the published version of this manuscript.

BMJ Open is an open access journal and the full, final, typeset and author-corrected version of record of the manuscript is available on our site with no access controls, subscription charges or pay-per-view fees (<http://bmjopen.bmj.com>).

If you have any questions on BMJ Open's open peer review process please email info.bmjopen@bmj.com

BMJ Open

**Measuring health literacy combining performance-based and perception-based measures.
The role of age, educational level and financial resources in predicting health literacy skills**

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2019-035987
Article Type:	Original research
Date Submitted by the Author:	25-Nov-2019
Complete List of Authors:	Lorini, Chiara; University of Florence, Department of Health Sciences Lastrucci, Vieri; University of Florence, Department of Health Sciences Paolini, Diana; University of Florence, Department of Health Sciences Research Group, Florence Health Literacy ; University of Florence, Department of Health Sciences Bonaccorsi, Guglielmo; University of Florence, Department of Health Sciences
Keywords:	PUBLIC HEALTH, PREVENTIVE MEDICINE, STATISTICS & RESEARCH METHODS

SCHOLARONE™
Manuscripts



I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our [licence](#).

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which [Creative Commons](#) licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

Measuring health literacy combining performance-based and perception-based measures.

The role of age, educational level and financial resources in predicting health literacy skills

Chiara Lorini¹, Vieri Lastrucci^{1*}, Diana Paolini¹, Florence Health Literacy Research Group[^], Guglielmo Bonaccorsi¹

[^]Florence Health Literacy Research Group: Elisabetta Alti³, Sergio Baglioni³, Angela Bechini¹, Leonardo Bellino³, Niccolò Berzi³, Jacopo Bianchi⁴, Sara Boccalini¹, Guglielmo Bonaccorsi¹, Giuseppe Burgio³, Alessandro Bussotti⁵, Marco Del Riccio¹, Martina Donzellini⁴, Angela Galdiero⁶, Alessandro Grassi³, Tommaso Grassi⁴, Vieri Lastrucci¹, Arrigo Lombardi³, Chiara Lorini¹, Sarah Mantwill², Federico Manzi⁴, Alessandro Mereu³, Donatella Messina³, Chiara Milani⁴, Diana Paolini¹, Marco Targonato³, Marco Toccafondi³, Gino Sartor⁴, Virginia Vettori¹

1. Department of Health Science, University of Florence, Florence, Italy
2. Department of Health Sciences & Health Policy, University of Lucerne, Lucerne, Switzerland
3. General Practitioner, Local Health Unit - Toscana Centro, Italy
4. School of Specialization in Hygiene and Preventive Medicine, University of Florence, Florence, Italy
5. Careggi University Hospital, Florence, Italy
6. Local Health Unit - Toscana Centro, Italy

*Corresponding author:

Vieri Lastrucci; e-mail: vieri.lastrucci@gmail.it; Postal address: Viale Morgagni, 48, 50134 Firenze, Italy

Abstract

Objective

To compare the results of self-performed based and perception-based measures of health literacy (HL) and to evaluate the contribution of their joint use in assessing some HL antecedents.

Design

Cross-sectional study

Setting

General population

Participants

This study is part of a larger one, where participants were randomly selected from the registries of eleven general practitioners (GPs) working in the municipality of Florence. Inclusion criteria were the following: 18-69 years of age and Italian speaking. Exclusion criteria included cognitive impairment, severe psychiatric diseases and end-stage diseases. In this paper, 220 adults (i.e. only the arm B of the larger study) were included.

Outcome measures

HL was measured using the European Health Literacy Survey Questionnaire (HLS-EU-Q16) and the Newest Vital Sign (NVS). The HL levels obtained by means of the two measurement tools were combined into a new variable, that described three different levels of HL skills: low HL skills; partial HL skills; high HL skills. Multivariate ordinal logistic regression analysis was performed to assess the predictive role of age class, educational level and financial resources with respect to HL skills.

Results

Twenty-two percent of the sample had high HL skills, 28.3% low HL skills, and 49.5% partial HL skills. Educational level, age class and financial resources were significantly associated with the HL skills, with OR values higher than those obtained using the NVS or the HLS-EU-Q16 individually.

Conclusion

1
2
3 The combination of the results obtained using the NVS and the HLS-EU-Q16 improve the understanding of
4
5 HL. The new variable generated by this combination could be considered a different way to assess HL and
6
7 its multidimensional contents.
8
9

10
11
12 **Trial registration number** CEAVC:10113.
13
14

15 16 17 **Strengths and limitations of this study** 18 19

- 20
21
22 • The population-based sample was obtained with a combination of convenience and probability
23
24 sampling procedures.
25
- 26
27 • In this study, for the first time, two different measures of health literacy (HL), namely the NVS for
28
29 functional HL and the HLS-EU-Q16 for general HL, were combined into a new variable
30
- 31
32 • The new variable, called “HL skills”, describes three possible conditions: “low HL skills” (low
33
34 functional and general HL); “partial HL skills” (low functional and general HL); “high HL skills” (high
35
36 functional and general HL)
37
- 38
39 • The new variable was entered as outcome variable in a multivariate logistic regression analysis,
40
41 considering age, educational level and financial resources as predictors
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Introduction

Health literacy (HL) is a multidimensional concept¹ and deal with broader competences that are needed to communicate, navigate and actively participate within modern health care systems and, more generally, with individual's capacity to assess, understand and use health information in different settings^{2,3}. The skills that compose HL can be classified in three different dimensions: the practical application of literacy skills ranging from those needed to be able to function effectively in everyday situations (functional); the cognitive and literacy skills which can be used to actively participate in everyday activities and to apply new information to changing circumstances (interactive); the cognitive skills which can be applied to critically analyse information, and to use this information to exert greater control over life events and situations (critical literacy)⁴. All these competences enable a person to navigate within three domains: healthcare, disease prevention and health promotion². For these reasons, HL affects people's health and it is now considered as one of the main determinants of health inequalities; it is significantly related with age, educational level and economic status⁵⁻⁸, and is supposed to partially mediate the effect of socioeconomic status on health-related outcomes^{9,10}.

To date several different definitions of HL have been proposed in the literature; as a result, a considerable number of measurement tools of HL have been developed by now. This variety of measurement tools rouses debate and poses some challenges. Indeed, more than 150 measures exist but no "gold standard" measure has never emerged till now; furthermore, only a small number of instruments examines multiple domains of HL (functional, interactive and critical), while the majority deals solely with the functional component, with the risk of fragmentation. On top of that, measurement tools may be classified as either performance-based (objective) or perception-based (subjective), so that they capture different aspects, for example the objective ability to understand medical information *versus* the effect of emotional or motivational aspects on decision-making process¹¹⁻¹⁴. As a consequence of the lack of a comprehensive approach to HL measurement, the use of different or fragmented HL measures led to difficulties in

1
2
3 comparing and/or to incomplete results in terms of HL levels and related outcomes, as well as to an
4
5 increasing risk of misinterpretations of the effectiveness of the interventions aimed at improving HL¹⁵⁻²⁰.

6
7 For these reasons, many Authors suggest measuring HL using different instrument at the same time, so as
8
9 to assess different skills, abilities and competences that constitute such a multidimensional construct^{11,21}.
10
11 Nevertheless, researches simultaneously using performance-based (*i.e.* direct testing of competences) and
12
13 perception-based (*i.e.* self-reported abilities) measures of different domains of HL remain scarce, and their
14
15 results are usually focused on highlighting the inconsistencies between the two types of tests, without
16
17 assessing their potential joint contribution to measuring HL as a unique concept^{15,22-24}.

18
19 Waters et al.²⁵, in a study conducted on patients affected by diabetes or colon cancer, found that
20
21 performance-based and perception-based HL measures represent related but independent constructs;
22
23 moreover, they are able to predict the objective disease knowledge - but not the perceived disease
24
25 knowledge - in the same way. Due to these results, the Author concluded that performance-based and
26
27 perception-based measures of HL are not interchangeable, although they tend to be consistent in
28
29 categorizing patients into different levels of HL²⁵. To the best of our knowledge, no studies adopting a
30
31 similar approach to the analysis of the HL determinants have been published by now.
32
33
34
35
36
37
38

39 The aim of this study is to compare the results of self-performed based and perception-based measures of
40
41 HL and to evaluate the potential contribution of their joint use in assessing some HL antecedents (age and
42
43 socio-economical determinants) in a population-based sample. We believe this is the first attempt to use
44
45 the information obtained with different HL measurement tools to get further insight into the knowledge of
46
47 the antecedents of HL.
48
49
50
51

52 **Methods**

53
54
55
56 This study is part of a larger one, conducted in a population-based sample in Florence, Italy, with the aim of
57
58 measuring HL level and to validate some HL measurement tools. The study design is described elsewhere²⁶,
59
60 as well as some of its results^{7,27}.

Data collection

The study adopted a cross-sectional design that was carried out in a population-based sample. Participants were randomly selected from the registries of eleven general practitioners (GPs) working in the municipality of Florence. The GPs were recruited using convenience criteria: according to the study protocol, the first eight who voluntarily join the study were included and were asked to randomly select 80 subjects among those registered as one of his/her patients. Since oversampling was not enough to reach the sample size of 480, three more GPs were included, with a second random sample for the first eight.

Inclusion criteria were the following: 18–69 years of age, and Italian speaking (since the survey was conducted in Italian). Exclusion criteria included cognitive impairment, severe psychiatric diseases and end-stage diseases. Each GP verified the inclusion and exclusion criteria when selecting the sample.

Each subject was randomly allocated to one of the two arms of the research project (A and B), according to the questionnaires used during the interview (type I and type II questionnaires, respectively). To meet the specific aims of the present study, only the B arm of the research was considered, since only in this arm the short form (16 items) of the European Health Literacy Survey Questionnaire (HLS-EU-Q16) was administered, together with the Italian version of the Newest Vital Sign (NVS-IT, hereinafter NVS). Overall, 984 subjects were selected (492 in the B arm of the study).

Data collection started in February 2017 and finished on 31st December 2017. Each selected subject was contacted via postal mail. Subjects received an information sheet signed by the GP and the person in charge of the study, which included a short description of the study, an invitation to participate, and a consent form. Participants were asked to sign the consent form and return it via mail to the researchers in charge. The mail also contained the nutritional label of the NVS. After receipt of the signed consent forms, the subjects were contacted for the computer-assisted telephone interview. Nine interviewers made the phone calls. Written instructions on how to conduct the interview were drawn up and shared to standardize the procedure and limit interviewer bias. Each subject was randomly assigned to one of the nine interviewers and contacted a maximum of six times before being considered unreachable.

1
2
3 The questionnaire had a general section that includes questions on sociodemographic, familial data
4 (antecedents), and health-related outcomes (consequences), as described in the previous papers^{7,26}. In
5
6
7 addition, the questionnaire included the NVS and the HLS-EU-Q16.

8
9 Age was collected as continuous variable, then grouped into four classes (18-45; 46-55; 56-65; >65 years
10
11 old). Educational level was classified into three levels (less than high school diploma; high school degree;
12
13 bachelor's degree and higher) while the financial status was investigated by the item "is your income
14
15 adequate to meet monthly living expenses?" with four possible response options (not enough; barely
16
17 enough; enough; more than enough).
18
19

20 21 22 23 *HL measures*

24
25 HL was measured using the NVS and the HLS-EU-Q16.

26
27 The Italian version of the NVS was validated by Capecchi et al. from the UK version form²⁸, then it was
28
29 applied in many different contexts^{29,30}. It consists of an ice cream nutrition label, with seven associated
30
31 questions that measure functional health literacy (prose and numeracy). It produces a final score ranging
32
33 from 0 to 6, allowing participants to be classified into three categories—high likelihood of limited HL (score:
34
35 0–1), possibility of limited HL (score: 2–3) and adequate HL (score: 4–6). NVS data related to the entire
36
37 sample of this study (A and B arms) have been described elsewhere⁷.
38
39

40
41 The European Health Literacy Survey was the first, large population study aimed at generating first-time
42
43 data on HL across diverse populations in the European Union³¹. To achieve this purpose, the European
44
45 Health Literacy Survey Questionnaire (HLS-EU-Q) for measuring HL was developed³² on the basis of the
46
47 recommendations of Pleasant et al.²⁰ regarding the characteristics that a comprehensive measure of HL
48
49 should have. In particular, starting from the HLS-EU Consortium conceptual framework of HL², the HLS-EU-
50
51 Q assesses the processes of accessing, understanding appraising and applying health-related information
52
53 within the three domains of health: healthcare, disease prevention and health promotion. It measures self-
54
55 perceived functional, critical and interactive HL (*i.e.* general HL). The original full version of the HLS-EU-Q is
56
57 constituted by 47 items (HLS-EU-Q47), and the HLS-EU-Q16 represents its short version that was developed
58
59 by selecting 16 items²⁴. The HLS-EU-Q16 has Likert-type responses ("very easy", "fairly easy", "fairly
60

1
2
3 difficult", "very difficult") and an associated final score that measures interaction, comprehension,
4 information seeking, application/function, decision-making/critical thinking, evaluation, responsibility,
5 confidence, and navigation skills. To generate the score of the HLS-EU-Q16, the items are dichotomized into
6 two categories with two scores, "easy" ("fairly" or "very" easy = 1) and "difficult" ("fairly" and "very"
7 difficult = 0). "Don't know/refusal" answer was recoded as missing. The scale score is calculated as the sum
8 of the scores of each item and varied between 0 and 16. As suggested by other studies^{23,33}, only
9 respondents who gave an answer to at least 14 items were considered. Three levels of HL were defined
10 considering the HLS-EU-Q16 score: inadequate HL (0-8), problematic HL (9-12) and sufficient HL (13-16). As
11 previously described, the Italian version of the HLS-EU-Q16 was validated in this study²⁷.

22 23 24 25 *Statistical analysis*

26 Fisher exact test was used to evaluate associations between categorical variables.

27
28 Multivariate ordinal logistic regression analysis was performed to assess the predictive role, expressed by
29 Odds Ratio (OR), of age class, educational level and financial resources with respect to HL skills, measured
30 combining the results obtained using the two tests (HLS-EU-Q16 and NVS). In particular, the dependent –
31 ordinal - variable had three levels:

- 32 1) "low HL skills" level that comprises high likelihood or possibility of limited HL measured by NVS and
33 inadequate or problematic HL measured by HLS-EU-Q16;
- 34 2) "partial HL skills" level that comprises high likelihood or possibility of limited HL measured by NVS
35 and sufficient HL measured by HLS-EU-Q16 or, conversely, adequate HL measured by NVS and
36 inadequate or problematic HL according to HLS-EU-Q16;
- 37 3) "high HL skills" level that comprises adequate HL measured by NVS and sufficient HL measured by
38 HLS-EU-Q16.

39
40 The OR obtained from this model was a measure of the change in the odds from lower to higher levels, *i.e.*
41 from lower to higher HL skills. For comparison, the same multivariate ordinal logistic regression analysis
42 was applied considering, as dependent –ordinal- variable, the level of HL measured by each single HL tests
43 (*i.e.* NVS and HLS-EU-Q16). Specifically, two models were developed: in the first one, the NVS level was the

1
2
3 dependent variable (1-high likelihood of limited HL; 2-possibility of limited HL; 3-adequate HL), while in the
4
5 second one the HLS-EU-Q16 level was the dependent variable (1- inadequate HL; problematic HL; 3-
6
7 sufficient HL).
8

9
10 Statistical analyses were conducted using Stata version 15 (Stata Corp, College Station, TX). All tests were
11
12 two-sided, and p-values were considered as statistically significant when below 0.05.
13
14
15

16 *Patient and public involvement*

17
18 The study population was not directly involved in the design, recruitment and conduct of this study.
19
20 However, the Florence Health Literacy Research Group involved representatives from Provincial Medical
21
22 Council, Local Health Unit and University Hospital of Florence. All of these representatives were involved in
23
24 the study design and questionnaire development and will disseminate the results from this work.
25
26
27
28
29

30 **Results**

31
32
33
34 A total of 452 subjects were interviewed (compliance equal to 46.1%) considering both arms of the
35
36 research project. The refusal rate was 15.6% of the invited people, while 38.2% of the invited people did
37
38 not respond to any contact attempts and was considered unreachable.
39

40
41 Two-hundred twelve subjects (58% females; mean age: 53.6 ±11.9 years) were interviewed in the B arm of
42
43 the study and the score for both HL measures was obtained. The majority of them (96.7%) were Italian,
44
45 with high school (36.3%) or university (45.3%) degree and had enough or more than enough financial
46
47 resources at disposal from own or family income to get to the end of the month (68.3%) (Table 1).
48

49
50 According to the HLS-EU-Q16, 11.8% had inadequate, 55.2% problematic and 33% sufficient HL; considering
51
52 the NVS, 10.4% had high likelihood of limited HL, 28.8% possibility of limited HL, 60.8% adequate HL (Table
53
54 1).
55

56
57 As for NVS, the HL levels was significantly ($p<0.05$) associated with age class, educational level and financial
58
59 resources, while when measured by HLS-EU-Q16 the HL levels were significantly ($p<0.05$) associated only
60
with education. The percentage of people with low HL was higher when it was measured by HLS-EU-Q16

1
2
3 than for NVS in each category of age class, educational level, and financial resources (Figure 1). For both
4
5 measures, the percentage of people with low HL increased with age and became more similar in older
6
7 people: for HLS-EU-Q16, from 59.2% for 18-45 to 78.4% for >65 years old; for NVS, from 20% for 18-45 to
8
9 67.5% for >65 years old. Similar results were observed for educational level and financial resources: for
10
11 both tests, the percentage of people with low HL increased with the decrease of educational level or
12
13 financial resources; in the lowest sub-categories (*i.e.* less than high school diploma or having not enough
14
15 financial resources), the percentage of people with low HL became similar between the two tests.
16
17

18
19 Combining the classification of both tests (Table 2), 22% of the sample had adequate level of functional
20
21 (measured by NVS) and sufficient general HL (measured by HLS-EU-Q16). On the other hand, 28.3%
22
23 presented both low functional HL (high likelihood or possibility of limited HL measured by NVS) and low
24
25 general HL (inadequate or problematic HL according to HLS-EU-Q16). However, the greater part of the
26
27 sample (49.5%) presented inconsistent HL measurements with low functional HL and sufficient general HL
28
29 or vice versa. In particular, the percentage of participants with adequate functional HL and low general HL
30
31 (38.7%) was higher than the percentage of participants with low functional HL and sufficient general HL
32
33 (10.8%).
34
35

36
37 The classification of the subjects into four HL groups (combining the two HL measures) was significantly
38
39 associated with age class, educational level, and financial resources (Figure 2). With the increasing of age,
40
41 the percentage of people with adequate HL for NVS and sufficient HL for HLS-EU-Q16 decreases: it was
42
43 similar between the 18-45 and 46-55 years old groups (about 30%), it halved in the 56-65 years old group,
44
45 and it halved again in the over 65 years old group. A similar tendency, although less markedly evident, was
46
47 observed for those with sufficient HL for HLS-EU-Q16 and low HL for NVS. At the same time, the percentage
48
49 of subjects with low HL for both tests increased with increasing age, ranging from 12.2% in the youngest
50
51 age group to 54.1% in the oldest age group. For what concern education, with the increasing of the
52
53 education level there was a decreasing of the percentage of people with low HL in both tests. The highest
54
55 percentage of subjects with adequate HL at NVS and sufficient HL at HLS-EU-Q16 was in the bachelor's
56
57 degree and higher group (35.4%), while the lowest percentage was registered in the high school degree
58
59 group (10.4%); the latter education group also presents the lowest percentage of people with sufficient HL
60

1
2
3 at HLS-EU-Q16 and low HL at NVS (9.1%) and the highest percentage of those with low HL at HLS-EU-Q16
4 and adequate HL at NVS (46.8%). Moreover, with the increase of the availability of financial resources it
5 increased the percentage of people with adequate HL at NVS and sufficient HL at HLS-EU-Q16 and, at the
6 same time, it decreased the percentage of people with low HL at both tests; in particular, the percentage of
7 people with low HL at both tests halved moving from the category “not enough” to “barely enough” (from
8 70% to 32.1%). Finally, in the more “disadvantages” groups (elderly people, low educational level, not
9 enough availability of financial resources), the percentage of people with discordant results regarding HL
10 level (i.e. low functional HL and sufficient general HL or vice versa) was lower than those obtained in the
11 other groups.
12
13
14
15
16
17
18
19
20
21
22

23 Educational level, age class and financial resources were entered as covariates in a multivariate ordinal
24 regression model, considering the HL skills (“low HL skills”, “partial HL skills”, “high HL skills”, according to
25 the combination of the classification obtained using the NVS and the HLS-EU-Q16) as outcome variable. All
26 the categories of the covariates showed significant associations with the outcome, with the exception of
27 “high school degree”, with an evident trend. Moreover, OR values were greater than 3 in most of the cases
28 (Table 3). In particular, the odds of having high HL skills were higher with the decreasing of age, the
29 increasing of financial resources, and for those who have bachelor’s degree and higher. Table 4 reported
30 the results of the same analyses conducted considering as dependent variable the level of HL according to
31 the NVS (I model) and to the HLS-EU-Q16 (II model). Considering the first model, functional HL significantly
32 increased with the decreasing of age and for people with bachelor’s degree and higher, while financial
33 resources did not show a predictive role. As regards to the second model, age class, educational level and
34 financial resources were not significantly associated with general HL.
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51

52 Discussion

53
54
55

56 The aim of the study was to compare two different measures of HL and to evaluate the potential
57 contribution of their joint use in assessing HL antecedents in a population-based sample. Our results
58 showed that NVS and HLS-EU-Q16 led to results that are not completely overlapped as a relevant
59
60

1
2
3 proportion of the population presented different HL levels when measured with different tools.
4
5 Furthermore, the antecedents of HL investigated in this study have a different weight in predicting NVS or
6
7 HLS-EU-Q16 results. These results indicate that they measure different aspects of HL; these findings are in
8
9 line with other studies conducted in other Countries^{22,34}.

10
11 A possible explanation for these findings may lay in the nature itself of the two HL measurement tool as the
12
13 HLS-EU-Q16 is a self-reported measure for general HL, while NVS is a performance-based measure of
14
15 reading, understanding and numeracy skills. In fact, what people think they know does not always
16
17 correspond to what they actually know: people tend to be overconfident (they think they know more than
18
19 they actually do) or underconfident (they think they know less than they actually do). Overconfidence and
20
21 underconfidence are a consequence of the matching between knowledge, confidence, self-efficacy, and
22
23 emotional distress³⁵⁻³⁸, and they may differ from country to country as they are also influenced by cultural
24
25 factors^{39,40}.

26
27
28
29
30 On the other hand, high skills in reading and understanding health related information (functional HL), do
31
32 not necessarily imply high critical and interactive competencies (included in general HL), that are related
33
34 also with problem-solving skills, life experiences, and empowerment^{41,42}. The simultaneous use of the two
35
36 HL measures has highlighted the presence of three well distinct HL groups in the population. A first group is
37
38 represented by the participants that had adequate level of functional and sufficient general HL: this group
39
40 have a broader range of HL skills (high HL skills), that can be used to participate actively in everyday
41
42 situations, extract health information and derive meaning from different forms of health communication,
43
44 applying this to changing circumstances, exert control over their care, and so on^{43,44}. A second group is
45
46 represented by the participants that presented both low functional HL and low general HL: these subjects
47
48 are lacking in a wide range of HL skills (low HL skills). Lastly, between these two opposite conditions, a third
49
50 group (partial HL skills) is represented by about half of the sample and includes all the participants that
51
52 presented inconsistent HL measurements with low functional HL and sufficient general HL or *vice versa*;
53
54 these people have some HL skills, but lack others.

55
56
57
58
59 As far as the demographic and socio-economic characteristics of the HL groups defined by the two HL
60
measures are concerned, it is interestingly to note that the more vulnerable population groups (the older,

1
2
3 less educated and poorer) presented the lower level of discrepancies in the results obtained with the two
4
5 HL tools, and in most of the cases, these groups presented low HL level in both the measures. On the
6
7 contrary, the youngest (18-45 years), those with high school degree and those with enough financial
8
9 resources presented the highest percentage of people with partial HL skills - low functional HL and
10
11 sufficient general HL in most of the cases.
12

13
14 As regard to the combination of the results obtained applying the two HL measures into a new variable –
15
16 *i.e.* HL skills, findings showed that the new variable strengthens the association between HL and the
17
18 investigated antecedents. Indeed, the comparison of the three models of multivariate ordinal logistic
19
20 regression showed that age, educational level and financial resources significantly and independently
21
22 predict HL skills with OR values generally higher than those observed in the models that consider each
23
24 single HL measure. These results suggest that a broader evaluation of HL dimensions - obtained integrating
25
26 the NVS and the HLS-EU-Q16 data - could better represent the real meaning of the complex and hard-to-
27
28 measure concept of HL. However, further researches are needed to confirm these results and to evaluate
29
30 whether this approach will also better predict the association between HL and health-related outcomes.
31
32

33
34 Moreover - as widely described for diagnostic and screening tests⁴⁵ - the use of parallel tests (*i.e.* two tests
35
36 performed at the same time and the results subsequently combined) results in an increase in sensitivity,
37
38 namely, in this case, the identification of people with low HL skills. For these reasons, the integrations of
39
40 different HL measures using an approach similar to the one used in this study may help to widen the
41
42 narrow view resulting from the use of a single measure and may serve as the basis for the design of a more
43
44 comprehensive measurement tool of HL. In this regard, it should be underlined that the approach of
45
46 integrating different HL measures is in line to what has been suggested by Pleasant et al.²⁰ for the definition
47
48 of comprehensive measure of HL: multi-dimensional in content and methodology.
49
50
51

52
53
54 This study has several limitations extensively discussed elsewhere⁷. One of the main limitations is that data
55
56 cannot be considered representative of the overall Italian or Florentine adult population since the
57
58 population-based sample was obtained with a combination of convenience and probability sampling
59
60 procedures. Although participants were randomly selected from the registers of the GPs, the GPs were

1
2
3 selected using convenience criteria, which may have introduced a selection bias. Moreover, results may
4
5 have been influenced by a non-response bias. Particularly, many enrolled people presented a high socio-
6
7 economic level (45.3% had bachelor's degree or higher and 17.4% more than enough financial resources).
8
9 These limits could influence external comparison of the study results (generalizability).
10
11
12
13

14 **Conclusion**

15
16
17
18 In conclusion, our findings suggest that the combination of the results obtained using a performance-based
19
20 measure of functional HL (the NVS) and a self-performed measure of general HL (HLS-EU-Q16) may improve
21
22 the understanding of HL skills of individuals and populations as well as of the relationship between HL and
23
24 its antecedents. In addition, the new variable generated by this combination of different HL measures (HL
25
26 skills) may help to better identify people with low HL skills and could be considered as a new measure of HL
27
28 or, at least, a different way to assess HL and its multidimensional contents. However, further studies are
29
30 needed to confirm our findings and to better define the potential of the combined use of different HL
31
32 measures.
33
34
35
36
37
38

39 **Acknowledgements**

40
41 The authors would like to thank Mauro Grazzini and Poste Italiane for their assistance in the study
42
43 implementation and conduct. The authors would also like to thank the subjects whose participation made
44
45 this study possible.
46
47
48
49

50 **Funding sources**

51
52 This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-
53
54 profit sectors
55
56
57
58

59 **Ethics approval**

1
2
3 The study was approved by the Ethics Committee of the 'Area Vasta Centro' (Local Health Unit of Tuscany-
4 Center, Careggi University Hospital and Meyer University Hospital; Ref. CEAVC: 10113, 01 December 2016).
5
6
7
8
9

10 **Author's contribution statement**

11 Chiara Lorini: conception and design of the study; analysis and interpretation of data; drafting and revision
12 of the manuscript.
13

14 Vieri Lastrucci: conception and design of the study; generation, collection, assembly and interpretation of
15 data; drafting and revision of the manuscript.
16

17 Diana Paolini: conception and design of the study; generation, collection, assembly and interpretation of
18 data; drafting and revision of the manuscript.
19

20 Guglielmo Bonaccorsi: conception and design of the study; interpretation of data; drafting and revision of
21 the manuscript.
22

23 Other component of the Florence Health Literacy Research Group: conception and design of the study;
24 generation, collection, assembly of data; drafting and revision of the manuscript.
25
26
27
28
29

30 **Conflict of interest statement**

31 The authors declare no conflict of interest
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Figures and Tables

Figure 1. Percentage of people with low health literacy by age class (A), educational level (B), and financial resources (C).

Figure 2. Percentage of people with regards to the two health literacy measures (HLS-EU-Q16 and NVS) by age class (A), educational level (B), and financial resources (C). For each graph, $p < 0.05$ (Fisher exact test).

For peer review only

Table 1. Descriptive analysis of the collected data (N=212).

Variables		N	%
Age class	18-45	49	23.1
	46-55	53	25.0
	56-65	73	34.4
	>65	37	17.5
Educational level	Less than high school diploma	39	18.4
	high school degree	77	36.3
	Bachelor's degree and higher	96	45.3
Financial resources at disposal from own or family income enough to get to the end of the month*	Not enough	10	4.7
	Barely enough	56	26.4
	Enough	108	50.9
	More than enough	37	17.4
NVS levels	high likelihood of limited HL	22	10.4
	possibility of limited HL	61	28.8
	adequate HL	129	60.8
HLS-EU-Q16 levels	Inadequate HL	25	11.8
	Problematic HL	117	55.2
	Sufficient HL	70	33.0

*1 missing value

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60**Table 2.** Level of health literacy considering both measures (NVS and HLS-EU-Q16).

		NVS		Total
		High likelihood or possibility of limited HL	Adequate HL	
HLS-EU-Q16	Inadequate or problematic HL	60 (28.3%)	82 (38.7%)	142 (67%)
	Sufficient HL	23 (10.8%)	47 (22.2%)	70 (33%)
Total		83 (39.1%)	129 (60.9%)	212 (100%)

Table 3. Multivariate ordinal logistic regression model (N=211). Dependent variable: HL skills, obtained combining the results of the two measures (HLS-EU-Q16 and NVS; “low HL skills”, “partial HL skills”, “high HL skills”). OR: Odds Ratio; SE: standard error.

Variables		OR	SE	P>z	[95% Conf. Interval]
Age class	>65	1	-	-	-
	56-65	2.36	0.982	0.038	[1.047; 5.334]
	46-55	4.85	2.180	<0.001	[2.010; 11.706]
	18-45	5.14	2.340	<0.001	[2.105; 12.543]
Educational level	Less than high school diploma	1	-	-	-
	High school degree	1.33	0.556	0.486	[0.591; 3.019]
	Bachelor’s degree and higher	3.72	1.555	0.002	[1.640; 8.442]
Financial resources at disposal from own or family income enough to get to the end of the month	Not enough	1	-	-	-
	Barely enough	5.500	4.289	0.029	[1.192; 25.359]
	Enough	5.573	4.215	0.023	[1.265; 24.540]
	More than enough	8.645	6.943	0.007	[1.791; 41.728]

LR chi2(10) =51.38; Prob > chi2<0.001; Log likelihood = -193.35519; Pseudo R2=0.1173

Table 4. Multivariate ordinal logistic regression models (N=211). In the first model, dependent variable: NVS (three levels); in the second model, dependent variable: HLS-EU-Q16 (three levels). OR: Odds Ratio; SE: standard error.

Variables		I model: NVS as dependent variable*				II model: HLS-EU-Q16 as dependent variable°			
		OR	SE	P>z	[95% Conf. Interval]	OR	SE	P>z	[95% Conf. Interval]
Age class	>65	1	-	-	-	1	-	-	-
	56-65	2.13	0.860	0.060	[0.962; 4.703]	1.45	0.580	0.357	[0.659; 3.176]
	46-55	5.84	2.740	<0.001	[2.329; 14.651]	1.60	0.690	0.271	[0.691; 3.730]
	18-45	7.17	3.572	<0.001	[2.700; 19.036]	1.95	0.857	0.126	[0.828; 4.615]
Educational level	Less than high school diploma	1	-	-	-	1	-	-	-
	High school degree	1.900	0.762	0.110	[0.865; 4.171]	0.65	0.259	0.285	[0.300; 1.424]
	Bachelor's degree and higher	3.781	1.545	0.001	[1.697; 8.425]	1.31	0.515	0.493	[0.606; 2.829]
Financial resources at disposal from own or family income enough to get to the end of the month	Not enough	1	-	-	-	1	-	-	-
	Barely enough	1.765	1.156	0.386	[0.489; 6.373]	2.310	1.561	0.215	[0.615; 8.686]
	Enough	3.396	2.178	0.057	[0.966; 11.937]	1.871	1.219	0.336	[0.522; 6.707]
	More than enough	2.910	2.057	0.131	[0.728; 11.637]	3.907	2.759	0.054	[0.979; 15.592]

* LR chi2(10) =50.6; Prob > chi2<0.001; Log likelihood = -163.36457; Pseudo R2=0.1341

° LR chi2(10) =15.64; Prob > chi2=0.0479; Log likelihood = -192.14072; Pseudo R2=0.0391

References

1. Kickbusch IS. Health literacy: Addressing the health and education divide. *Health Promot Int* 2001;**16**:289–97. <https://doi.org/10.1093/heapro/16.3.289>.
2. Sørensen K, Van den Broucke S, Fullam J, *et al*. Consortium Health Literacy Project European. Health literacy and public health: a systematic review and integration of definitions and models. *BMC Public Health* 2012;**12**:80. doi: 10.1186/1471-2458-12-80.
3. Van den Broucke S. Health literacy: a critical concept for public health. *Arch Public Health* 2014;**72**: 10. doi: 10.1186/2049-3258-72-10.
4. Nutbeam D. The evolving concept of health literacy. *Soc Sci Med* 2008;**67**:2072–8. doi: 10.1016/j.socscimed.2008.09.050.
5. Kickbusch I, Pelikan LM, Apfel F, *et al*. *Health literacy. The solid facts*. Copenhagen: World Health Organisation Regional Office for Europe, 2013.
6. Kobayashi L, Wardle J, Wolf MS, *et al*. Aging and functional health literacy: a systematic review and meta-analysis. *J Gerontol B Psychol Sci Soc Sci* 2016;**71**:445-57. doi: 10.1093/geronb/gbu161.
7. Bonaccorsi G, Lastrucci V, Vettori V, *et al*. Functional Health Literacy in a population-based sample in Florence: an assessment using the Newest Vital Sign. *BMJ Open* 2019;**9**:e026356. doi: 10.1136/bmjopen-2018-026356.
8. Adams RJ, Appleton SL, Hill CL, *et al*. Risks associated with low functional health literacy in an Australian population. *Med J Aust* 2009;**191**:530–4.
9. Stormacq C, Van den Broucke S, Wosinski J. Does health literacy mediate the relationship between socioeconomic status and health disparities? Integrative review. *Health Promot Int* 2018. doi: 10.1093/heapro/day062.
10. Pelikan JM, Ganahl K, Roethlin F. Health literacy as a determinant, mediator and/or moderator of health: empirical models using the European Health Literacy Survey dataset. *Glob Health Promot* 2018;**25**:57-66. doi: 10.1177/1757975918788300.
11. Nguyen TH, Paasche-Orlow MK, McCormack LA. The State of the Science of Health Literacy Measurement. *Stud Health Technol Inform* 2017;**240**:17-33. doi: 10.3233/ISU-170827.

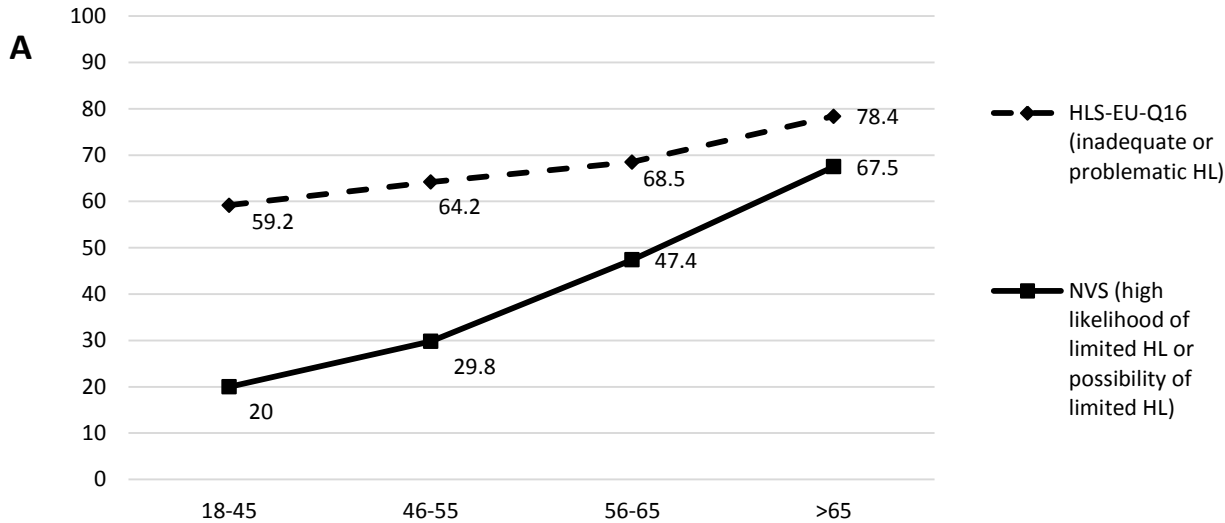
12. Altin SV, Finke I, Kautz-Freimuth S, Stock S. The evolution of health literacy assessment tools: a systematic review. *BMC Public Health* 2014;**14**:1207. doi: 10.1186/1471-2458-14-1207.
13. Haun JN, Valerio MA, McCormack LA, *et al.* Health literacy measurement: an inventory and descriptive summary of 51 instruments. *J Health Commun* 2014;**19**:302-33. doi: 10.1080/10810730.2014.936571.
14. Jordan JE, Osborne RH, Buchbinder R. Critical appraisal of health literacy indices revealed variable underlying constructs, narrow content and psychometric weaknesses. *J Clin Epidemiol* 2011;**64**:366-79. doi: 10.1016/j.jclinepi.2010.04.005.
15. Kiechle ES, Bailey SC, Hedlund LA, *et al.* Different Measures, Different Outcomes? A Systematic Review of Performance-Based versus Self-Reported Measures of Health Literacy and Numeracy. *J Gen Intern Med* 2015;**30**:1538-46. doi: 10.1007/s11606-015-3288-4.
16. Marciano L, Camerini AL, Schulz PJ. The Role of Health Literacy in Diabetes Knowledge, Self-Care, and Glycemic Control: a meta-analysis. *J Gen Intern Med* 2019;**34**:1007-17. doi: 10.1007/s11606-019-04832-y.
17. Malloy-Weir L, Cooper M. Health literacy, literacy, numeracy and nutrition label understanding and use: a scoping review of the literature. *J Hum Nutr Diet* 2017;**30**:309-25. doi: 10.1111/jhn.12428.
18. Lorini C, Santomauro F, Donzellini M, *et al.* Health literacy and vaccination: A systematic review. *Hum Vaccin Immunother* 2018;**14**:478-88. doi: 10.1080/21645515.2017.
19. Griffin JM, Partin MR, Noorbaloochi S, *et al.* Variation in estimates of limited health literacy by assessment instruments and non-response bias. *J Gen Intern Med* 2010;**27**:675-81. doi: 10.1007/s11606-010-1304-2.
20. Pleasant A, McKinney J, Rikard RV. Health Literacy measurement: a proposed research agenda. *J Health Commun* 2011;**16**:11-21. doi: 10.1080/10810730.2011.604392.
21. McCormack L, Haun J, Sørensen K, *et al.* Recommendations for advancing health literacy measurement. *J Health Commun* 2013;**18**:9-14. doi: 10.1080/10810730.2013.829892.
22. HLS-EU Consortium. Comparative report on health literacy in eight EU member states. The European health literacy survey HLS-

- 1
2
3 EU. 2012 [http://ec.europa.eu/chafea/documents/news/Comparative_report_on_health_literacy_i](http://ec.europa.eu/chafea/documents/news/Comparative_report_on_health_literacy_in_eight_EU_member_states.pdf)
4 [n_eight_EU_member_states.pdf](http://ec.europa.eu/chafea/documents/news/Comparative_report_on_health_literacy_in_eight_EU_member_states.pdf)
5
6
7
8 23. Almaleh R, Helmy Y, Farhat E, *et al.* Assessment of health literacy among outpatient clinics
9 attendees at Ain Shams University Hospitals. Egypt: a cross-sectional study. *Public Health*
10 2017;**151**:137-45. doi: 10.1016/j.puhe.2017.06.024.
11
12
13
14 24. Pelikan JM, Ganahl K. Measuring health literacy in general populations: Primary findings from the
15 HLS-EU Consortium's Health Literacy Assessment Effort. *Stud Health Technol Inf* 2017;**240**:34-59.
16
17
18 doi: 10.3233/978-1-61499-790-0-34.
19
20
21 25. Waters EA, Biddle C, Kaphingst KA, *et al.* Examining the Interrelations Among Objective and
22 Subjective Health Literacy and Numeracy and Their Associations with Health Knowledge. *J Gen*
23 *Intern Med* 2018;**33**:1945-53. doi: 10.1007/s11606-018-4624-2.
24
25
26
27 26. Lorini C, Santomauro F, Grazzini M, *et al.* Health literacy in Italy: a cross-sectional study protocol to
28 assess the health literacy level in a population-based sample and to validate health literacy
29 measures in the Italian language. *BMJ Open* 2017;**7**: 017812. doi: 10.1136/bmjopen-2017-017812.
30
31
32
33 27. Lorini C, Lastrucci V, Mantwill S, *et al.* Measuring health literacy in Italy: a validation study of the
34 HLS-EU-Q16 and of the HLS-EU-Q6 in Italian language, conducted in Florence and its surroundings.
35
36
37
38 *Ann Ist Super Sanita* 2019;**55**: 10-8. doi: 10.4415/ANN_19_01_04.
39
40
41 28. Capecchi L, Guazzini A, Lorini C, *et al.* The first Italian validation of the most widespread health
42 literacy assessment tool: the Newest Vital Sign. *Epidemiol Prev* 2015;**39**: 124-8.
43
44
45
46 29. Bonaccorsi G, Pieralli F, Innocenti M, *et al.* Non-familial paid caregivers as potential flu carriers and
47 cause of spread: the primary prevention of flu measured through their adhesion to flu vaccination
48 campaigns - A Florentine experience. *Hum Vaccin Immunother* 2019;**2**:1-7. doi:
49
50
51
52 10.1080/21645515.2019.1593726.
53
54
55 30. Bonaccorsi G, Grazzini M, Pieri L, *et al.* Assessment of Health Literacy and validation of single-item
56 literacy screener (SILS) in a sample of Italian people. *Ann Ist Super Sanita* 2017;**53**:205-12. doi:
57
58
59 10.4415/ANN_17_03_05.
60

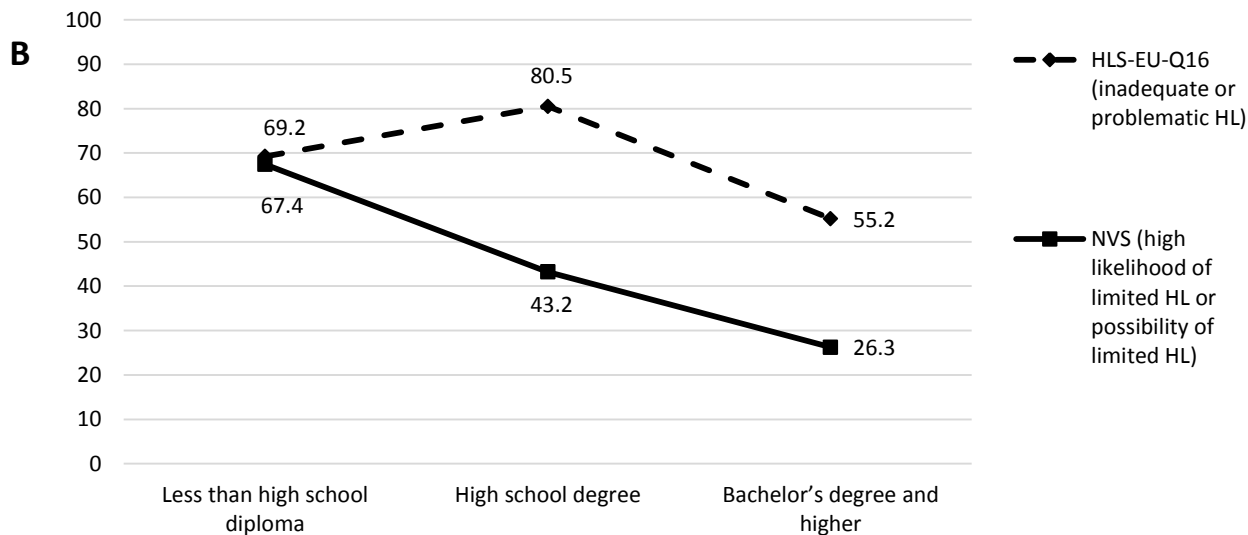
- 1
2
3 31. Sørensen K, Pelikan JM, Röthlin F, *et al.* Health literacy in Europe: comparative results of the
4 European health literacy survey (HLS-EU). *Eur J Public Health* 2015;**25**:1053-8. doi:
5 10.1093/eurpub/ckv043.
6
7
8
9
10 32. Sørensen K, Van den Broucke S, Pelikan JM, *et al.* Measuring health literacy in populations:
11 illuminating the design and development process of the European Health Literacy Survey
12 Questionnaire (HLS-EU-Q). *BMC Public Health* 2013;**13**: 948. doi: 10.1186/1471-2458-13-948.
13
14
15
16 33. Halbach SM, Ernstmann N, Kowalski C, *et al.* Unmet information needs and limited health literacy in
17 newly diagnosed breast cancer patients over the course of cancer treatment. *Patient Educ Couns*
18 2016;**99**:1511-18. doi: 10.1016/j.pec.2016.06.028.
19
20
21
22
23 34. Fransen MP, Leenaars KE, Rowlands G, *et al.* International application of health literacy measures:
24 adaptation and validation of the newest vital sign in The Netherlands. *Patient Educ Couns*
25 2014;**97**:403-9. doi: 10.1016/j.pec.2014.08.017.
26
27
28
29
30 35. Alba JW. Knowledge calibration what consumers know and what they think they know. *J Consum*
31 *Res* 2000;**72**:123-65. <https://doi.org/10.1086/314317>.
32
33
34 36. Carlson JP, Vincent LH, Hardesty DM, *et al.* Objective and subjective knowledge relationships: a
35 quantitative analysis of consumer research findings. *J Consum Res* 2009;**35**:864-76.
36
37 <https://doi.org/10.1086/593688>.
38
39
40
41 37. Pieniak S, Aertsens J, Verbeke W. Subjective and objective knowledge as determinants of organic
42 vegetables consumption. *Food Qual Preference* 2010;**21**:581-88.
43
44 <https://doi.org/10.1016/j.foodqual.2010.03.004>.
45
46
47
48 38. Schinckus L, Dangois F, Van den Broucke S, *et al.* When knowing is not enough: Emotional
49 distress and depression reduce the positive effects of health literacy on diabetes self-management.
50
51 *Patient Educ Couns* 2018;**101**:324-30. doi: 10.1016/j.pec.2017.08.006.
52
53
54 39. Stolp S, Zabucky KM. Contributions of metacognitive and self-regulated learning theories to
55 investigations of calibration of comprehension. *International Electronic Journal of Elementary*
56 *Education* 2017;**2**:7-31.
57
58
59
60

- 1
2
3 40. Belmi P, Neale MA, Reiff D. *et al.* The social advantage of miscalibrated individuals: the relationship
4
5 between social class and overconfidence and its implications for class-based inequality. *J Pers Soc*
6
7 *Psychol* (2019). doi: 10.1037/pspi0000187
8
9
10 41. Crondahl K, Karlsson LE. The nexus between health literacy and empowerment: a scoping review.
11
12 *Sage Open* 2016;**6**:1-7. <https://doi.org/10.1177/2158244016646410>
13
14 42. Nutbeam D. Health literacy as a public health goal: a challenge for contemporary health education
15
16 and communication strategies into the 21st century. *Health Prom Intern* 2000;**15**:259-67.
17
18 <https://doi.org/10.1093/heapro/15.3.259>.
19
20 43. Chinn D. Critical health literacy: a review and critical analysis. *Soc Sci Med* 2011;**73**:60-7. doi:
21
22 10.1016/j.socscimed.2011.04.004.
23
24 44. Van der Heide I, Heijmans M, Schuit AJ, *et al.* Functional, interactive and critical health literacy:
25
26 varying relationships with control over care and number of GP visits. *Patient Educ Couns*
27
28 2015;**98**:998-1004. doi: 10.1016/j.pec.2015.04.006.
29
30 45. Fletcher RH, Fletcher SH, Fletcher Grant S. *Clinical epidemiology: the essentials, fifth ed.*, Lippincott
31
32 Williams & Wilkins, Philadelphia 2012.
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

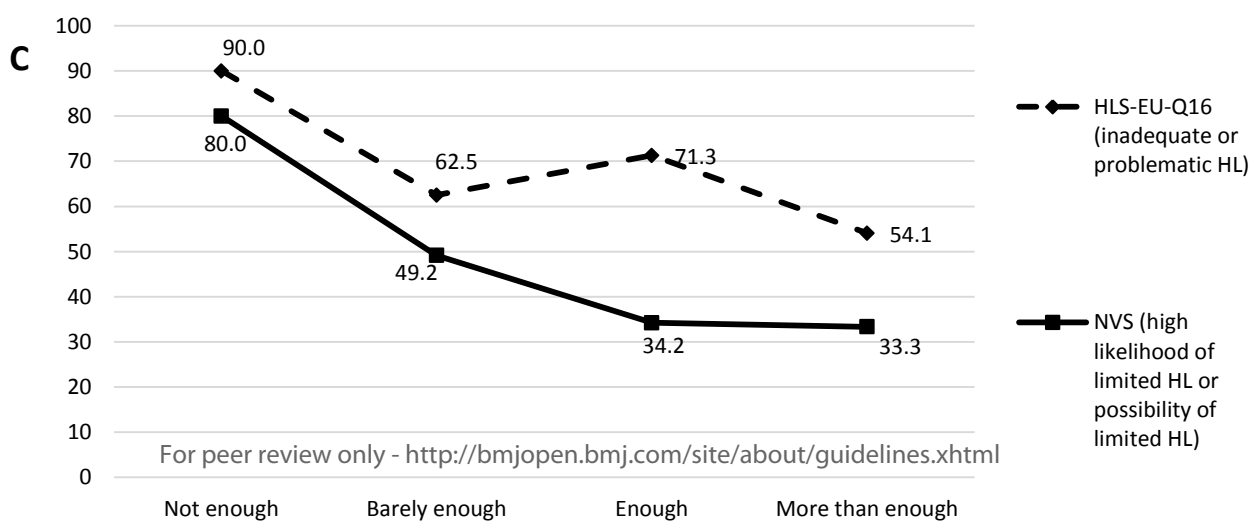
Low Health Literacy by age class (%)

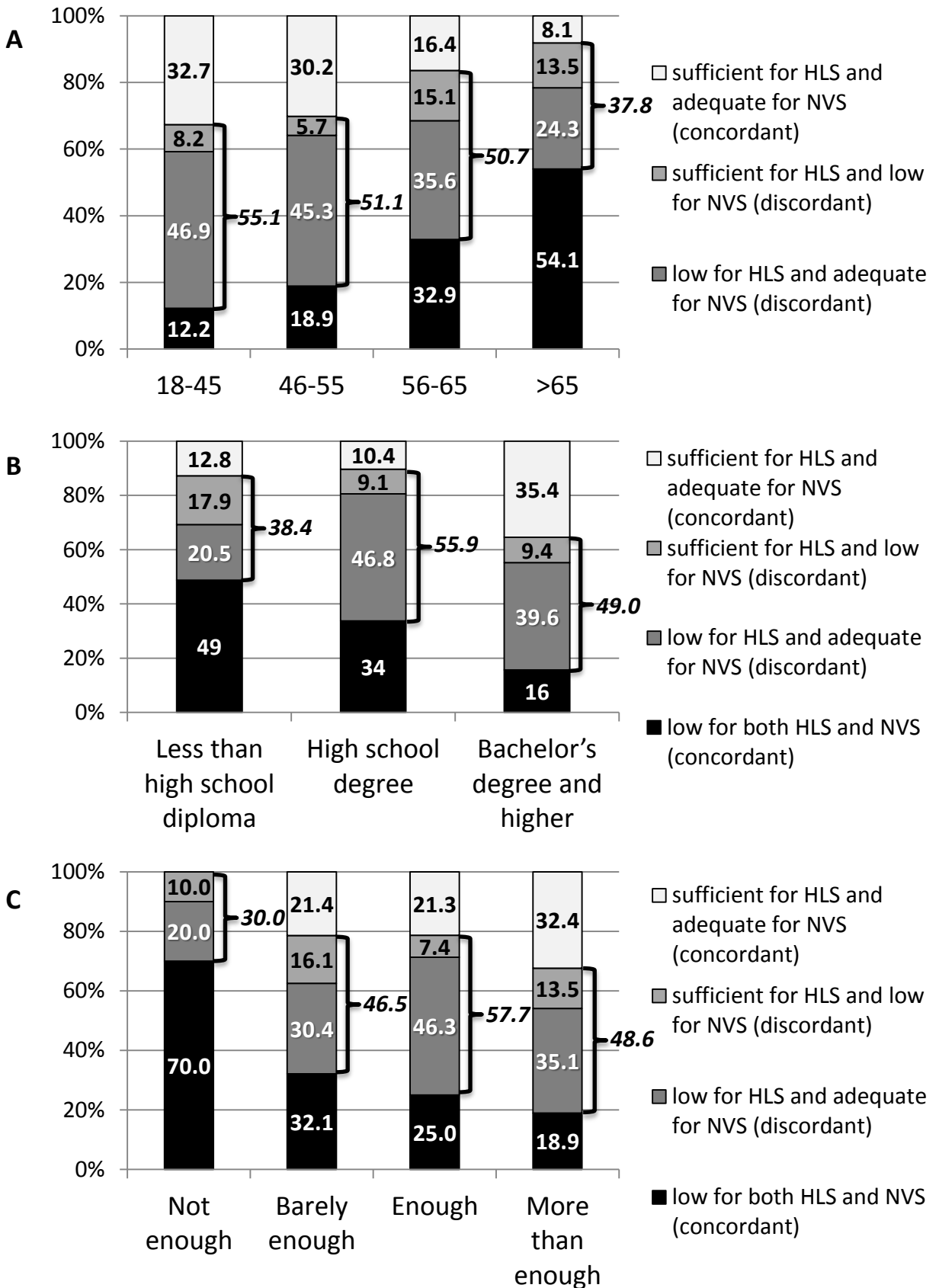


Low Health Literacy by educational level (%)



Low Health Literacy by Financial resources (%)





STROBE 2007 (v4) Statement—Checklist of items that should be included in reports of cross-sectional studies

Section/Topic	Item #	Recommendation	Reported on page #
Title and abstract	1	(a) Indicate the study's design with a commonly used term in the title or the abstract	
		(b) Provide in the abstract an informative and balanced summary of what was done and what was found	2
Introduction			
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported	4; 5
Objectives	3	State specific objectives, including any prespecified hypotheses	5
Methods			
Study design	4	Present key elements of study design early in the paper	6
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection	6
Participants	6	(a) Give the eligibility criteria, and the sources and methods of selection of participants	6
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable	6; 7; 8
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group	6;7; 8
Bias	9	Describe any efforts to address potential sources of bias	8
Study size	10	Explain how the study size was arrived at	5;6
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why	8
Statistical methods	12	(a) Describe all statistical methods, including those used to control for confounding	8
		(b) Describe any methods used to examine subgroups and interactions	8
		(c) Explain how missing data were addressed	
		(d) If applicable, describe analytical methods taking account of sampling strategy	
		(e) Describe any sensitivity analyses	
Results			

Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed	9
		(b) Give reasons for non-participation at each stage	9
		(c) Consider use of a flow diagram	
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders	9; 10
		(b) Indicate number of participants with missing data for each variable of interest	17
Outcome data	15*	Report numbers of outcome events or summary measures	9; 10; 11
Main results	16	(a) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included	19; 20
		(b) Report category boundaries when continuous variables were categorized	17; 18; 19; 20
		(c) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period	
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses	
Discussion			
Key results	18	Summarise key results with reference to study objectives	11
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias	13
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence	12; 13
Generalisability	21	Discuss the generalisability (external validity) of the study results	12; 13
Other information			
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based	14

*Give information separately for cases and controls in case-control studies and, if applicable, for exposed and unexposed groups in cohort and cross-sectional studies.

Note: An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at <http://www.plosmedicine.org/>, Annals of Internal Medicine at <http://www.annals.org/>, and Epidemiology at <http://www.epidem.com/>). Information on the STROBE Initiative is available at www.strobe-statement.org.

BMJ Open

**Measuring health literacy combining by performance-based and self-assessed measures.
The roles of age, educational level, and financial resources in predicting health literacy skills: a cross-sectional study conducted in Florence (Italy)**

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2019-035987.R1
Article Type:	Original research
Date Submitted by the Author:	24-Mar-2020
Complete List of Authors:	Lorini, Chiara; University of Florence, Department of Health Sciences Lastrucci, Vieri; University of Florence, Department of Health Sciences Paolini, Diana; University of Florence, Department of Health Sciences Research Group, Florence Health Literacy ; University of Florence, Department of Health Sciences Bonaccorsi, Guglielmo; University of Florence, Department of Health Sciences
Primary Subject Heading:	Public health
Secondary Subject Heading:	Research methods
Keywords:	PUBLIC HEALTH, PREVENTIVE MEDICINE, STATISTICS & RESEARCH METHODS

SCHOLARONE™
Manuscripts



I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our [licence](#).

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which [Creative Commons](#) licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

1
2
3 **Measuring health literacy combining by performance-based and self-assessed measures.**
4

5 **The roles of age, educational level, and financial resources in predicting health literacy skills: a**
6
7
8 **cross-sectional study conducted in Florence (Italy)**
9

10
11
12 Chiara Lorini¹, Vieri Lastrucci^{1*}, Diana Paolini¹, Florence Health Literacy Research Group[^], Guglielmo
13
14 Bonaccorsi¹
15
16

17
18
19 [^]Florence Health Literacy Research Group: Elisabetta Alti³, Sergio Baglioni³, Leonardo Bellino³, Niccolò Berzi³,
20
21 Jacopo Bianchi⁴, Guglielmo Bonaccorsi¹, Giuseppe Burgio³, Alessandro Bussotti⁵, Marco Del Riccio¹, Martina
22
23 Donzellini⁴, Angela Galdiero⁶, Alessandro Grassi³, Tommaso Grassi⁴, Vieri Lastrucci¹, Arrigo Lombardi³, Chiara
24
25 Lorini¹, Sarah Mantwill², Federico Manzi⁴, Alessandro Mereu³, Donatella Messina³, Chiara Milani⁴, Diana
26
27 Paolini¹, Marco Targonato³, Marco Toccafondi³, Gino Sartor⁴, Virginia Vettori¹
28
29
30

- 31
32
33 1. Department of Health Science, University of Florence, Florence, Italy
34
35 2. Department of Health Sciences & Health Policy, University of Lucerne, Lucerne, Switzerland
36
37 3. General Practitioner, Local Health Unit - Toscana Centro, Italy
38
39 4. School of Specialization in Hygiene and Preventive Medicine, University of Florence, Florence, Italy
40
41
42 5. Careggi University Hospital, Florence, Italy
43
44 6. Local Health Unit - Toscana Centro, Italy
45
46
47

48 *Corresponding author:
49

50 Vieri Lastrucci; e-mail: vieri.lastrucci@gmail.com; Postal address: Viale Morgagni, 48, 50134 Firenze, Italy
51
52
53
54
55
56
57
58
59
60

Abstract

Objective

The objective was to compare the results of performance-based and self-assessed measures of health literacy (HL) and to evaluate the contribution of their joint use in assessing some HL antecedents.

Design

This was a cross-sectional study.

Setting

The study was conducted on the general population.

Participants

This study is part of a larger one, where participants were randomly selected from the registries of eleven general practitioners (GPs) working in the municipality of Florence. Inclusion criteria were the following: 18-69 years of age and Italian speaking. Exclusion criteria included cognitive impairment, severe psychiatric disease, or end-stage disease. In this paper, 212 adults were included.

Outcome measures

HL was measured using the European Health Literacy Survey Questionnaire (HLS-EU-Q16) and the Newest Vital Sign (NVS). The HL levels obtained by means of the two measurement tools were combined into a new variable that described three different levels of HL skills: low HL skills, partial HL skills, and high HL skills. Multivariate ordinal logistic regression analysis was performed to assess the predictive roles of age class, educational level, and financial resources with respect to HL skills.

Results

Twenty-two percent of the sample had high HL skills, 28.3% had low HL skills, and 49.5% had partial HL skills. Educational level, age class and financial resources were significantly associated with HL skills, with OR values being higher than those obtained using the NVS or the HLS-EU-Q16 individually.

Conclusion

1
2
3 The combination of the results obtained using the NVS and the HLS-EU-Q16 improves the understanding of
4
5 HL. The new variable generated by this combination could be considered as a different way to assess HL and
6
7 its multidimensional contents.
8
9

10
11
12 **Trial registration number** CEAVC:10113.
13
14

15 16 17 **Strengths and limitations of this study** 18 19

- 20
21
22 • In this study, for the first time, two different measures of health literacy (HL) were combined into a
23
24 new variable, called “HL skills”.
25
26 • The study design (sampling procedure, criteria for the combination of the HL measures) led to
27
28 limitations in the generalizability of the results.
29
30 • A different approach in combining the two measures could have led to different results.
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Introduction

Health literacy (HL) is a multidimensional concept¹ that deals with broader competences that are needed to communicate, navigate, and actively participate within modern health care systems and, more generally, with an individual's capacity to assess, understand, and use health information in different settings^{2,3}. The skills that compose HL can be classified into three different typologies: the practical application of literacy skills ranging from those needed to be able to function effectively in everyday situations (functional); the cognitive and literacy skills that can be used to actively participate in everyday activities and to apply new information to changing circumstances (interactive); and cognitive skills that can be applied to critically analyse information and exert greater control over life events and situations (critical literacy)⁴. All of these competences enable a person to navigate within three domains: healthcare, disease prevention, and health promotion². For these reasons, HL affects people's health, and it is now considered as one of the main determinants of health inequality; it is significantly related to age, educational level, and economic status⁵⁻⁸ and is suggested to partially mediate the effect of socioeconomic status on health-related outcomes^{9,10,11}. Moreover, HL can also be considered as the balance between individual skills and the demands and complexities of societal systems¹²; it is the combination of cognitive capacities, life experiences, knowledge, and opportunities^{13,14}.

To date, several different definitions of HL have been proposed in the literature; as a result, a considerable number of HL measurement tools have been developed by now. Although this variety of measures permits the use of specific tools for specific aims and target groups, it rises debate and poses some challenges. Indeed, more than 150 measures exist, but no "gold standard" measure has emerged until now. Furthermore, only a small number of instruments examine multiple types of HL (functional, interactive, and critical), while the majority deal solely with the functional component, with the risk of fragmentation. Apart from that, measurement tools may be classified as either performance-based (objective) or self-assessed (subjective), as they capture different aspects, for example, the objective ability to understand medical information versus the effect of emotional or motivational aspects on the decision-making process¹⁵⁻¹⁸. As a consequence of the

1
2
3 lack of a comprehensive approach to HL measurement, the use of different or fragmented HL measures leads
4
5 to difficulties in comparing and/or to incomplete results in terms of the HL level and related outcomes, as
6
7 well as to an increasing risk of misinterpreting the effectiveness of interventions aimed at improving HL¹⁹⁻²⁴.

8
9 Besides, while performance-based tools can be assumed to objectively measure HL regardless of a person's
10
11 environment, self-assessed ones can be considered to be more situation specific; for instance, emotional or
12
13 motivational aspects of the decision-making process are also the consequence of family, community, and
14
15 system support¹³.

16
17 For these reasons, many authors suggest measuring HL using different instruments at the same time, so as
18
19 to assess different skills, abilities, and competences that constitute such a multidimensional construct¹⁵⁻²⁵.

20
21 Nevertheless, research using performance-based (i.e., direct testing of competences) and self-assessed
22
23 (perception-based, i.e., self-reported abilities) measures of different dimensions and types of HL
24
25 simultaneously remains scarce, and the results of such studies are usually focused on highlighting the
26
27 inconsistencies between the two types of tests, without assessing their potential joint contribution to
28
29 measuring HL as a unique concept^{14,19,26,27}.

30
31 In a study conducted on patients affected by diabetes or colon cancer, Waters et al.²⁸ found that
32
33 performance-based and self-assessed HL measures represent related but independent constructs; they are
34
35 able to predict objective disease knowledge but not perceived disease knowledge in the same way. Due to
36
37 these results, the author concluded that performance-based and self-assessed measures of HL are not
38
39 interchangeable, although they tend to be consistent in categorizing patients into different levels of HL²⁸. To
40
41 the best of our knowledge, no studies adopting a similar approach to the analysis of the HL determinants
42
43 have been published as yet.

44
45 The aim of this study is to compare the results of performance-based and self-assessed measures of HL and
46
47 to evaluate the potential contribution of their joint use in assessing some HL antecedents (age and socio-
48
49 economical determinants) in a population-based sample. We believe that this is the first attempt to use the
50
51

1
2
3 information obtained by different HL measurement tools to get further insight into the knowledge about the
4 antecedents of HL.
5
6
7
8
9

10 **Methods**

11
12
13

14 This study is part of a larger one, conducted in a population-based sample in Florence, Italy, with the aim of
15 measuring the HL level and validating some HL measurement tools. The study design is described
16 elsewhere²⁹, as well as some of its results³⁰.
17
18
19
20
21
22

23 *Data collection*

24

25 The study adopted a cross-sectional design that was carried out in a population-based sample. Participants
26 were randomly selected from the registries of eleven general practitioners (GPs) working in the municipality
27 of Florence. The municipality of Florence is about 102 km² in size, with a population density of about 3500
28 inhabitants/km²; socio-economic and health deprivation data are described elsewhere³¹.
29
30
31
32
33

34 The sample size of the study was calculated considering the first aim of the larger study (i.e., to assess the
35 level of functional HL using the Newest Vital Sign (NVS) in a population sample in Florence, Italy), as described
36 elsewhere⁷, and it was equal to 480 participants.
37
38
39

40
41 The GPs were recruited using convenience criteria: all of the GPs from the municipality of Florence were
42 invited to join the study by both the Provincial Medical Council and the University Hospital of Florence.
43 According to the study protocol, the first eight who voluntarily joined the study were included and were
44 asked to select 80 subjects among those registered as patients using a simple random sampling method.
45 Since oversampling was not enough to reach the sample size of 480, three more GPs were included, with a
46 second random sample for the first eight. In Italy, every resident over the age of 18 has to be registered in a
47 general practice, and people are enrolled in the general practices according to their place of residence. This
48 sampling method was chosen with the aim of increasing the population participation rate, as the invitation
49 letter was jointly signed by the general practitioners and the researcher in charge of the study.
50
51
52
53
54
55
56
57
58
59
60

1
2
3 The sample was selected within each neighbourhood of the municipality of Florence, since the recruited
4
5 general practices were based in all the areas of Florence.
6

7 The inclusion criteria were the following: 18–69 years of age and Italian speaking (since the survey was
8
9 conducted in Italian). The inclusion criteria were defined according to those of the Italian behavioural risk
10
11 factor surveillance system PASSI (*Progressi delle Aziende Sanitarie per la Salute in Italia*)³². The exclusion
12
13 criteria included cognitive impairment, severe psychiatric disease, or end-stage diseases. Each GP verified
14
15 the inclusion and exclusion criteria when selecting the sample.
16
17

18 The larger study included two different arms (A and B) with different aims and questionnaires. Each subject
19
20 was randomly allocated to one of the two arms. To meet the specific aims of the present study, only the B
21
22 arm of the research was considered, since the short form (16 items) of the European Health Literacy Survey
23
24 Questionnaire (HLS-EU-Q16) was only administered in this arm, together with the Italian version of the
25
26 Newest Vital Sign (NVS-IT, hereinafter, NVS).
27
28

29 Data collection started in February 2017 and finished on 31 December 2017. Each selected subject was
30
31 contacted via postal mail. Subjects received an information sheet signed by the GP and the person in-charge
32
33 of the study, which included a short description of the study, an invitation to participate, and a consent form.
34
35 Participants were asked to sign the consent form and return it via mail to the researchers in charge. The mail
36
37 also contained the nutritional label of the NVS. After receipt of the signed consent forms, the subjects were
38
39 contacted for a computer-assisted telephone interview. If the consent form was not received within 2 weeks,
40
41 a follow-up phone call was made by the research group. The phone call served to clarify any questions and
42
43 to identify and support people having difficulty completing the consent form (i.e., due to reading difficulty).
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
Nine interviewers made the phone calls. Written instructions on how to conduct the interviews were drawn
up and shared to standardize the procedure and limit interviewer bias. Each subject was randomly assigned
to one of the nine interviewers and contacted a maximum of six times before being considered unreachable.
The questionnaire had a general section that included questions on sociodemographic, familial data
(antecedents), and health-related outcomes (consequences), as described in the previous papers²⁹. In
addition, the questionnaire included the NVS and the HLS-EU-Q16.

1
2
3 Age was collected as a continuous variable and then grouped into four classes (18–45; 46–55; 56–65; >65
4 years old). Education was classified into three levels (less than high school diploma; high school degree;
5 bachelor’s degree and higher), while the financial status was investigated by the item “Is your income
6 adequate to meet monthly living expenses?” with four possible response options (not enough; barely
7 enough; enough; more than enough). This item was chosen since it is routinely used in the standardized
8 questionnaire of the Italian behavioural risk factor surveillance system PASSI³³.
9
10
11
12
13
14
15
16
17

18 *HL measures*

19
20
21 HL was measured using the NVS and the HLS-EU-Q16. The Italian version of the NVS was validated by
22 Capecchi et al. from the UK version³⁴, and then it was applied in many different contexts^{35,36}. It consists of an
23 ice cream nutrition label with seven associated questions that measure functional HL (prose and numeracy)
24 using a performance-based approach. It produces a final score ranging from 0 to 6, allowing participants to
25 be classified into three categories—high likelihood of limited HL (score: 0–1), possibility of limited HL (score:
26 2–3), and adequate HL (score: 4–6). These cut-off values were identified by Weiss et al. in a validation study
27 of the NVS, conducted in English-speaking and Spanish-speaking primary care patients, in which the HL
28 measured using the Test of Functional Health Literacy in Adults (TOFHLA) was considered as a reference³⁷.
29
30 The HL categories defined using the two cut off values (1 and 3) are widely used in many countries.
31
32 NVS data related to the entire sample of the study (A and B arms) have been described elsewhere⁷.
33
34
35
36
37
38
39
40
41
42

43 The European Health Literacy Survey was the first large population study aimed at generating first-time data
44 on HL across diverse populations in the European Union³⁸. To achieve this purpose, the European Health
45 Literacy Survey Questionnaire (HLS-EU-Q) for measuring HL was developed³⁹ on the basis of the
46 recommendations of Pleasant et al.²⁴ regarding the characteristics that a comprehensive measure of HL
47 should have. In particular, starting from the HLS-EU Consortium conceptual framework of HL², the HLS-EU-Q
48 assesses the processes of accessing, understanding, appraising, and applying health-related information
49 within the three domains of health: healthcare, disease prevention, and health promotion. It measures self-
50 assessed functional, critical, and interactive HL (i.e., general HL). The original full version of the HLS-EU-Q
51
52
53
54
55
56
57
58
59
60

1
2
3 comprises 47 items (HLS-EU-Q47), and the HLS-EU-Q16 is its short version that was developed by selecting
4
5 16 items²⁷. The HLS-EU-Q16 has Likert-type responses (“very easy”, “fairly easy”, “fairly difficult”, “very
6
7 difficult”) and an associated final score that measures interaction, comprehension, information seeking,
8
9 application/function, decision-making/critical thinking, evaluation, responsibility, confidence, and navigation
10
11 skills. To generate the score of the HLS-EU-Q16, the items are dichotomized into two categories with two
12
13 scores: “easy” (“fairly” or “very” easy = 1) and “difficult” (“fairly” and “very” difficult = 0). “Don’t
14
15 know/refusal” was recoded for missing answers. The scale score was calculated as the sum of the scores of
16
17 each item and varied between 0 and 16. As suggested by other studies^{26,40}, only respondents who gave an
18
19 answer to at least 14 items were considered. Three levels of HL were defined considering the HLS-EU-Q16
20
21 score: inadequate HL (0–8), problematic HL (9–12) and sufficient HL (13–16). The cut-off values for defining
22
23 the three levels were described by Pelikan et al. using the results of the European Health Literacy Survey,
24
25 with respect to the results obtained using the HLS-EU-Q47⁴¹, and then have been widely used.
26
27
28 As previously described, the Italian version of the HLS-EU-Q16 was validated in this study³⁰.

31 32 33 34 *Statistical analysis*

35
36 The Fisher exact test was used to evaluate associations between categorical variables.

37
38 A new variable, named “HL skills”, was defined by combining the results obtained using the two tests (HLS-
39
40 EU-Q16 and NVS). The criterion used for combining the two measures was a simple approach that allowed
41
42 to different levels of skills to be identified. In particular, the variable was created as follows:

- 43
44
45 1) “low HL skills” level that comprises a high likelihood or possibility of limited HL measured by NVS and
46
47 inadequate or problematic HL measured by HLS-EU-Q16;
 - 48
49
50 2) “partial HL skills” level that comprises a high likelihood or possibility of limited HL measured by NVS
51
52 and sufficient HL measured by HLS-EU-Q16 or, conversely, adequate HL measured by NVS and
53
54 inadequate or problematic HL according to HLS-EU-Q16;
 - 55
56
57 3) “high HL skills” level that comprises adequate HL measured by NVS and sufficient HL measured by
58
59 HLS-EU-Q16.
- 60

1
2
3 The subjects classified among those with “low HL skills” presented some limitations in both functional and
4 general HL; those with “partial HL skills” presented some limitation either in functional or in general HL; while
5 those with “high HL skills” presented the highest level of HL skills in both functional and general HL.
6
7
8

9
10 A multivariate ordinal logistic regression analysis⁴² was performed to assess the predictive roles of age class,
11 educational level, and financial resources with respect to “HL skills”. Specifically, “HL skills” was the
12 dependent ordinal variable while age class, educational level, and financial resources were the independent
13 ordinal variables (covariates). In ordinal logistic regression model, the predictive role is expressed as the
14 proportional odds ratio (OR), and it can be interpreted in the same way as ORs are interpreted for the
15 conventional logistic regression for binary outcomes. The OR obtained from this model was a measure of the
16 change in the odds from lower to higher levels, i.e., from lower to higher HL skills. As a comparison, the same
17 multivariate ordinal logistic regression analysis was applied considering the level of HL measured by each
18 single HL test (i.e., NVS and HLS-EU-Q16) as a dependent ordinal variable. Specifically, two models were
19 developed: in the first one, the NVS level was the dependent variable (1—high likelihood of limited HL; 2—
20 possibility of limited HL; 3—adequate HL), while in the second one, the HLS-EU-Q16 level was the dependent
21 variable (1—inadequate HL; 2—problematic HL; 3—sufficient HL).
22
23
24
25
26
27
28
29
30
31
32
33
34
35

36 Statistical analyses were conducted using Stata version 15 (Stata Corp, College Station, TX). All tests were
37 two-sided, and p-values were considered to be statistically significant when below 0.05.
38
39
40
41
42

43 *Patient and public involvement*

44
45 The study population was not directly involved in the design, recruitment, and conduct of this study.
46
47 However, the Florence Health Literacy Research Group involved representatives from the Provincial Medical
48 Council, Local Health Unit, and University Hospital of Florence. All of these representatives were involved in
49
50 the study design and questionnaire development and will disseminate the results from this work.
51
52
53
54
55

56 **Results**

1
2
3 The refusal rate was 15.6%, while 38.2% of the invited people did not respond to any contact attempts and
4 were considered unreachable. Finally, 212 subjects (58% females; mean age: 53.6 ±11.9 years) were
5 interviewed for the purpose of this study. The majority of them (96.7%) were Italian, with a high school
6 (36.3%) or university (45.3%) degree, and had enough or more than enough financial resources at their
7 disposal from their own or family income to get to the end of the month (68.3%) (Table 1).
8
9

10
11
12
13
14 According to the HLS-EU-Q16, 11.8% had inadequate, 55.2% had problematic, and 33% had sufficient HL;
15 considering the NVS, 10.4% had a high likelihood of having limited HL, 28.8% had a possibility of having
16 limited HL, and 60.8% had adequate HL (Table 1).
17
18

19
20 As for NVS, the HL levels were significantly ($p < 0.05$) associated with age class, educational level, and financial
21 resources, while when measured by HLS-EU-Q16, the HL levels were significantly ($p < 0.05$) associated only
22 with education. The percentage of people with low HL was higher when it was measured by HLS-EU-Q16 than
23 for NVS in each category of age class, educational level, and financial resources (Figure 1). For both measures,
24 the percentage of people with low HL increased with age and became more similar in older people: for HLS-
25 EU-Q16, it ranged from 59.2% for those aged 18–45 to 78.4% for those >65 years old; for NVS, it ranged from
26 20% for those aged 18–45 to 67.5% for those aged >65 years old. Similar results were observed for
27 educational level and financial resources: for both tests, the percentage of people with low HL increased with
28 a decrease in educational level or financial resources; in the lowest sub-categories (i.e., less than high school
29 diploma or not having enough financial resources), the percentage of people with low HL became similar
30 between the two tests.
31
32

33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Combining the classifications of both tests (Table 2), 22% of the sample had adequate levels of functional
(measured by NVS) and sufficient general HL (measured by HLS-EU-Q16). On the other hand, 28.3%
presented both low functional HL (high likelihood or possibility of limited HL measured by NVS) and low
general HL (inadequate or problematic HL according to HLS-EU-Q16). However, a greater part of the sample
(49.5%) presented inconsistent HL measurements with low functional HL and sufficient general HL or vice
versa. In particular, the percentage of participants with adequate functional HL and low general HL (38.7%)
was higher than the percentage of participants with low functional HL and sufficient general HL (10.8%).

1
2
3 The classification of the subjects into four HL groups (combining the two HL measures) was significantly
4 associated with age class, educational level, and financial resources (Figure 2; Table S1). With an increase in
5 age, the percentage of people with adequate HL for NVS and sufficient HL for HLS-EU-Q16 decreased; the
6 percentage was similar between the 18–45 and 46–55 year-old age groups (about 30%), it halved in the 56–
7 65 year-old age group, and it halved again in the over 65 year-old age group. A similar tendency, although
8 less markedly evident, was observed for those with sufficient HL for HLS-EU-Q16 and low HL for NVS. At the
9 same time, the percentage of subjects with low HL for both tests increased with increasing age, ranging from
10 12.2% in the youngest age group to 54.1% in the oldest age group. Regarding education, with an increase in
11 the education level, there was a decrease in the percentage of people with low HL in both tests. The highest
12 percentage of subjects with adequate HL at NVS and sufficient HL at HLS-EU-Q16 was in the bachelor's degree
13 and higher group (35.4%), while the lowest percentage was registered in the high school degree group
14 (10.4%); the latter education group also presented the lowest percentage of people with sufficient HL at HLS-
15 EU-Q16 and low HL at NVS (9.1%) and the highest percentage of those with low HL at HLS-EU-Q16 and
16 adequate HL at NVS (46.8%). Moreover, with the increase in the availability of financial resources, the
17 percentage of people with adequate HL at NVS and sufficient HL at HLS-EU-Q16 increased, and, at the same
18 time, the percentage of people with low HL in both tests decreased; in particular, the percentage of people
19 with low HL in both tests halved, moving from the category “not enough” to “barely enough” (from 70% to
20 32.1%). Finally, in the more “disadvantaged” groups (elderly people, low educational level, not enough
21 availability of financial resources), the percentage of people with discordant results regarding the HL level
22 (i.e., low functional HL and sufficient general HL or vice versa) was lower than that obtained in the other
23 groups.

24
25 Considering the results of the multivariate ordinal regression model, all categories of the covariates showed
26 significant associations with the outcome, with the exception of “high school degree”, with an evident trend.
27 Moreover, OR values were greater than 3 in most cases (Table 3). In particular, the odds of having high HL
28 skills were higher as age decreased (OR value from 2.36 for 56–65 years old, to 5.14 for 18–45 years old),
29 financial resources increased (OR value from 5 for “barely enough” resources, to 8.65 for “more than enough”
30

resources), and for those with a bachelor's degree or higher (OR = 3.72). Table 4 reported the results of the same analyses conducted considering the level of HL as a dependent variable in accordance with the NVS (I model) and the HLS-EU-Q16 (II model). Considering the first model, functional HL significantly increased as age decreased (for those 46–55 years old: OR = 5.84; for those 18–45 years old: OR = 7.17) and for people with a bachelor's degree or higher (OR = 3.78), while financial resources did not show a predictive role. Regarding the second model, age class, educational level, and financial resources were not significantly associated with general HL.

Discussion

The aim of the study was to compare two different measures of HL and to evaluate the potential contribution of their joint use in assessing HL antecedents in a population-based sample. Our results showed that NVS and HLS-EU-Q16 led to results that did not completely overlap, as a relevant proportion of the population presented different HL levels when measured with different tools. Furthermore, the antecedents of HL investigated in this study have different weights in predicting NVS or HLS-EU-Q16 results. These results indicate that they measure different aspects of HL; these findings are in line with other studies conducted in other countries^{14,43}.

A possible explanation for these findings may lay in the nature of the two HL measurement tools, as the HLS-EU-Q16 is a self-assessed measure for general HL, while NVS is a performance-based measure of reading, understanding, and numeracy skills. In fact, what people think they know does not always correspond to what they actually know: people tend to be overconfident (they think they know more than they actually do) or underconfident (they think they know less than they actually do). Overconfidence and underconfidence are a consequence of the matching between knowledge, confidence, self-efficacy, and emotional distress⁴³⁻⁴⁷, and they may differ from country to country, as they are also influenced by cultural factors^{48,49}.

On the other hand, high skills in reading and understanding health related information (functional HL) do not necessarily imply high critical and interactive competencies (included in general HL), as these are also related

1
2
3 to problem-solving skills, life experiences, and empowerment^{50,51}. In fact, HL could also act as a balance
4
5 between individual skills and the demands and complexities of societal systems¹². Since it represents the
6
7 combination of cognitive capacities, life experiences, knowledge, and opportunities^{13,14}, it can be influenced
8
9 by the social environment in which it is assessed; this feature should and could be considered to tailor
10
11 interventions aimed at increasing its levels.
12

13
14 The simultaneous use of the two HL measures highlights the presence of three distinct HL groups in the
15
16 population. A first group is represented by the participants with an adequate level of functional and sufficient
17
18 general HL; this group has a broader range of HL skills (high HL skills) that can be used to participate actively
19
20 in everyday situations, extract health information, and derive meaning from different forms of health
21
22 communication. This can be applied to changing circumstances, to exert control over their care, and so
23
24 on^{52,53}. A second group is represented by the participants that presented with both low functional HL and
25
26 low general HL. These subjects lack a wide range of HL skills (low HL skills). Lastly, between these two
27
28 opposing conditions, a third group (partial HL skills) is represented by about half of the sample and includes
29
30 all the participants that presented with inconsistent HL measurements with low functional HL and sufficient
31
32 general HL or vice versa; these people have some HL skills, but lack others.
33
34
35

36
37 As far as the demographic and socio-economic characteristics of the HL groups defined by the two HL
38
39 measures are concerned, it is interesting to note that the more vulnerable population groups (the older, less
40
41 educated, and poorer) presented lower levels of discrepancy in the results obtained with the two HL tools,
42
43 and in most of cases, these groups presented a low HL level for both measures. On the contrary, the youngest
44
45 participants (18–45 years), those with a high school degree and those with enough financial resources
46
47 presented the highest percentage of people with partial HL skills low functional HL and sufficient general HL
48
49 in most cases. There seems to be a social gradient in accessing, understanding, appraising, and applying
50
51 information that is useful for adopting appropriate behaviours in everyday life, and in this sense, HL reflects
52
53 the disadvantage suffered by the most deprived people regarding education and wealth.
54

55
56 Regarding the combination of the results obtained by applying the two HL measures into a new variable, i.e.,
57
58 HL skills, findings showed that the new variable strengthens the association between HL and the investigated
59
60

1
2
3 antecedents. Indeed, the comparison of the three models of multivariate ordinal logistic regression showed
4 that age, educational level, and financial resources significantly and independently predict HL skills, with OR
5 values generally being higher than those observed in the models that consider each single HL measure. These
6 results suggest that a broader evaluation of HL dimensions—obtained by integrating the NVS and the HLS-
7 EU-Q16 data—could better represent the real meaning of the complex and hard-to-measure concept of HL.
8 However, further research is needed to confirm these results and to evaluate whether this approach will also
9 better predict the association between HL and health-related outcomes.

10
11 Moreover, as widely described for diagnostic and screening tests⁵⁴, the use of parallel tests (i.e., two tests
12 administered at the same time followed by subsequent combination of the results) results in an increase in
13 sensitivity—in this case, the identification of people with low HL skills. For these reasons, the integration of
14 different HL measures using an approach similar to the one used in this study may help to widen the narrow
15 view resulting from the use of a single measure and may serve as the basis for the design of a more
16 comprehensive measurement tool for HL. In this regard, it should be underlined that the approach of
17 integrating different HL measures is in line with what has been suggested by Pleasant et al.²⁴ for the definition
18 of a comprehensive measure of HL: multi-dimensional in content and methodology.

19
20 This study has several limitations. Some of them are related to the sampling procedure. In particular, one of
21 the main limitations is that the data cannot be considered representative of the overall Italian or Florentine
22 adult population since the population-based sample was obtained with a combination of convenience and
23 probability sampling procedures. For this reason, the generalizability of the results to the entire Florentine
24 population is limited. In fact, although participants were randomly selected from the registers of the GPs, the
25 GPs were selected using convenience criteria, which may have introduced a selection bias. Additionally,
26 results may have been influenced by a non-response bias. Particularly, many of the enrolled people had a
27 high socio-economic level (45.3% had a bachelor's degree or higher and 17.4% had more than enough
28 financial resources). These limits could influence an external comparison of the study results, since age,
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 educational level, and financial resources are determinants of HL. Sex was not included in the analysis since,
4
5 at the univariate analysis, it was not significantly associated with HL.
6
7
8
9

10 Other limitations are related to the cut-off values of both the NVS and the HLS-EU-Q16 that were used to
11 categorize the levels of HL. Although widely-used thresholds were applied, these cut-offs have not been
12 previously validated for the Italian population, since large population-based studies using the NVS and HLS-
13 EU-Q16 have not been performed yet. Moreover, some alternatives could have been considered for the
14 combination of the two variables. In particular, one of them could be the combination of the items of the
15 two measures into a single scale and assessing the reliability using the classic approach. The chosen
16 methodology is related to the aim of giving an initial, simple approach for assessing the possibility of
17 integrating different measures of HL, and this will be refined with future studies.
18
19
20
21
22
23
24
25
26
27
28
29

30 **Conclusion**

31
32
33
34 In conclusion, our findings suggest that the combination of the results obtained using a performance-based
35 measure of functional HL (the NVS) and a self-assessed measure of general HL (HLS-EU-Q16) may improve
36 the understanding of the HL skills of individuals and populations as well as the relationship between HL and
37 its antecedents. In addition, the new variable generated by this combination of different HL measures (HL
38 skills) may help to better identify people with low HL skills and could be considered as a new measure of HL
39 or, at least, a different way of assessing HL and its multidimensional contents. Although further studies are
40 needed to confirm our findings and to better define the potential of the combined use of different HL
41 measures, we think that this paper can be considered to be a starting point for a novel approach to the
42 investigation of HL, regardless of the limits of this research,.
43
44
45
46
47
48
49
50
51
52
53

54 Moreover, the results of our study seem to be in line with the evolution of HL proposed by The Secretary's
55 Advisory Committee on US National Health Promotion and Disease Prevention Objectives for Healthy People
56 2030: "Health literacy occurs when a society provides accurate health information and services that people
57
58
59
60

1
2
3 can easily find, understand, and use to inform their decisions and actions.” Nowadays, we should consider
4
5 HL to be a type of social competence and responsibility, and we should measure all its facets to make it a
6
7 discipline that can contribute to a higher level of clarity, accessibility, and actionability, so as to reduce
8
9 inequalities in health⁵⁵.

14 **Funding sources**

16 This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-
17
18 profit sectors.

23 **Data availability**

25 The dataset generated and analysed during the current study is available from the corresponding author on
26
27 reasonable request.

32 **Ethics approval**

34 The study was approved by the Ethics Committee of the ‘Area Vasta Centro’ (Local Health Unit of Tuscany-
35
36 Center, Careggi University Hospital and Meyer University Hospital; Ref. CEAVC: 10113, 01 December 2016).

41 **Author's contribution statement**

43 Chiara Lorini: conception and design of the study; analysis and interpretation of data; drafting and revision
44
45 of the manuscript.

47 Vieri Lastrucci: conception and design of the study; generation, collection, assembly and interpretation of
48
49 data; drafting and revision of the manuscript.

51 Diana Paolini: conception and design of the study; generation, collection, assembly and interpretation of
52
53 data; drafting and revision of the manuscript.

55 Guglielmo Bonaccorsi: conception and design of the study; interpretation of data; drafting and revision of
56
57 the manuscript.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Other component of the Florence Health Literacy Research Group: conception and design of the study; generation, collection, assembly of data; drafting and revision of the manuscript.

For peer review only

Conflict of interest statement

The authors declare no conflict of interest

Figures and Tables

Figure 1. Percentage of people with low health literacy by age class (A), educational level (B), and financial resources (C).

Figure 2. Percentage of people with regards to the two health literacy measures (HLS-EU-Q16 and NVS) by age class (A), educational level (B), and financial resources (C). For each graph, $p < 0.05$ (Fisher exact test).

Table 1. Descriptive analysis of the collected data (N = 212).

Variables		N	%
Age class	18–45	49	23.1
	46–55	53	25.0
	56–65	73	34.4
	>65	37	17.5
Educational level	Less than high school diploma	39	18.4
	High school degree	77	36.3
	Bachelor's degree and higher	96	45.3
Financial resources at disposal from own or family income enough to get to the end of the month*	Not enough	10	4.7
	Barely enough	56	26.4
	Enough	108	50.9
	More than enough	37	17.4
NVS level	High likelihood of limited HL	22	10.4
	Possibility of limited HL	61	28.8
	Adequate HL	129	60.8
HLS-EU-Q16 levels	Inadequate HL	25	11.8
	Problematic HL	117	55.2
	Sufficient HL	70	33.0

*1 missing value. HL: health literacy; HLS-EU-Q16: European Health Literacy Survey Questionnaire; NVS:

Newest Vital Sign.

Table 2. Level of health literacy considering both measures (NVS and HLS-EU-Q16).

		NVS		Total
		High likelihood or possibility of limited HL	Adequate HL	
HLS-EU-Q16	Inadequate or problematic HL	60 (28.3%)	82 (38.7%)	142 (67%)
	Sufficient HL	23 (10.8%)	47 (22.2%)	70 (33%)
Total		83 (39.1%)	129 (60.9%)	212 (100%)

Table 3. Multivariate ordinal logistic regression model (N = 211). Dependent variable: HL skills, obtained combining the results of the two measures (HLS-EU-Q16 and NVS; “low HL skills”, “partial HL skills”, “high HL skills”). OR: Odds Ratio; SE: standard error; CI: Confidence Interval.

Variables		OR (95%CI)	P>z
Age class	>65	1	-
	56-65	2.36 (1.05–5.33)	0.038
	46-55	4.85 (2.01–11.71)	<0.001
	18-45	5.14 (2.10–12.54)	<0.001
Educational level	Less than high school diploma	1	-
	High school degree	1.33 (0.59–3.02)	0.486
	Bachelor’s degree and higher	3.72 (1.64–8.44)	0.002
Financial resources at disposal from own or family income enough to get to the end of the month	Not enough	1	-
	Barely enough	5.50 (1.19–25.36)	0.029
	Enough	5.57 (1.26–24.54)	0.023
	More than enough	8.65 (1.79–41.73)	0.007

LR $\chi^2(10) = 51.38$; Prob > $\chi^2 < 0.001$; Log likelihood = -193.35519 ; Pseudo R² = 0.1173

Table 4. Multivariate ordinal logistic regression models (N = 211). In the first model, dependent variable: NVS (three levels); in the second model, dependent variable: HLS-EU-Q16 (three levels). OR: Odds Ratio; SE: standard error; CI: Confidence Interval.

Variables		I model: NVS as dependent variable*		II model: HLS-EU-Q16 as dependent variable°	
		OR (95%CI)	P>z	OR (95%CI)	P>z
Age class	>65	1	-	-	-
	56–65	2.13 (0.96–4.70)	0.060	1.45 (0.66–3.18)	0.357
	46–55	5.84 (2.33–14.65)	<0.001	1.60 (0.69–3.73)	0.271
	18–45	7.17 (2.70–19.04)	<0.001	1.95 (0.88–4.61)	0.126
Educational level	Less than high school diploma	1	-	-	-
	High school degree	1.90 (0.86–4.17)	0.110	0.65 (0.30–1.42)	0.285
	Bachelor's degree and higher	3.78 (1.70–8.42)	0.001	1.31 (0.62–2.83)	0.493
Financial resources at disposal from own or family income enough to get to the end of the month	Not enough	1	-	-	-
	Barely enough	1.76 (0.49–6.37)	0.386	2.31 (0.61–8.69)	0.215
	Enough	3.40 (0.97–11.94)	0.057	1.87 (0.54–6.71)	0.336
	More than enough	2.91 (0.73–11.64)	0.131	3.91 (0.98–15.60)	0.054

* LR $\chi^2(10) = 50.6$; Prob > $\chi^2 < 0.001$; Log likelihood = -163.36457 ; Pseudo R² = 0.1341

° LR $\chi^2(10) = 15.64$; Prob > $\chi^2 = 0.0479$; Log likelihood = -192.14072 ; Pseudo R² = 0.0391

References

1. Kickbusch IS. Health literacy: Addressing the health and education divide. *Health Promot Int* 2001;**16**:289–97. <https://doi.org/10.1093/heapro/16.3.289>.
2. Sørensen K, Van den Broucke S, Fullam J, *et al*. Consortium Health Literacy Project European. Health literacy and public health: a systematic review and integration of definitions and models. *BMC Public Health* 2012;**12**:80. doi: 10.1186/1471-2458-12-80.
3. Van den Broucke S. Health literacy: a critical concept for public health. *Arch Public Health* 2014;**72**: 10. doi: 10.1186/2049-3258-72-10.
4. Freebody P, Luke A. 'Literacies' programs: debates and demands in cultural context. *Prospect* 1990;**5**: 7-16.
5. Kickbusch I, Pelikan LM, Apfel F, *et al*. *Health literacy. The solid facts*. Copenhagen: World Health Organisation Regional Office for Europe, 2013.
6. Kobayashi L, Wardle J, Wolf MS, *et al*. Aging and functional health literacy: a systematic review and meta-analysis. *J Gerontol B Psychol Sci Soc Sci* 2016;**71**:445-57. doi: 10.1093/geronb/gbu161.
7. Bonaccorsi G, Lastrucci V, Vettori V, *et al*. Functional Health Literacy in a population-based sample in Florence: an assessment using the Newest Vital Sign. *BMJ Open* 2019;**9**:e026356. doi: 10.1136/bmjopen-2018-026356.
8. Adams RJ, Appleton SL, Hill CL, *et al*. Risks associated with low functional health literacy in an Australian population. *Med J Aust* 2009;**191**:530–4.
9. Stormacq C, Van den Broucke S, Wosinski J. Does health literacy mediate the relationship between socioeconomic status and health disparities? Integrative review. *Health Promot Int* 2018. doi: 10.1093/heapro/day062.
10. Pelikan JM, Ganahl K, Roethlin F. Health literacy as a determinant, mediator and/or moderator of health: empirical models using the European Health Literacy Survey dataset. *Glob Health Promot* 2018;**25**:57-66. doi: 10.1177/1757975918788300.

- 1
2
3 11. Lastrucci V, Lorini C, Caini S, *et al*. Health literacy as a mediator of the relationship between
4 socioeconomic status and health: A cross-sectional study in a population-based sample in Florence.
5 *PLoS One* 2019;**14**(12):e0227007. doi: 10.1371/journal.pone.0227007.
6
7
8
9
10 12. Parker R. Measuring health literacy: What? So what? Now what. In: *Measures of health literacy:*
11 *workshop summary*. Washington, DC: National Academies Press, 2009.
12
13
14 13. Levin-Zamir D, Leung AYM, Dodson S, Rowlands G. Health Literacy in Selected Populations:
15 Individuals, Families, and Communities From the International and Cultural Perspective. *Stud Health*
16 *Technol Inform* 2017;**240**:392-414.
17
18
19
20 14. HLS-EU Consortium. Comparative report on health literacy in eight EU member states. The European
21 health literacy survey HLS-
22 EU. 2012 [http://ec.europa.eu/chafea/documents/news/Comparative_report_on_health_literacy_i](http://ec.europa.eu/chafea/documents/news/Comparative_report_on_health_literacy_in_eight_EU_member_states.pdf)
23 [n_eight_EU_member_states.pdf](http://ec.europa.eu/chafea/documents/news/Comparative_report_on_health_literacy_in_eight_EU_member_states.pdf)
24
25
26
27
28
29
30 15. Nguyen TH, Paasche-Orlow MK, McCormack LA. The state of the science of health literacy
31 measurement. *Stud Health Technol Inform* 2017;**240**:17-33. doi: 10.3233/ISU-170827.
32
33
34 16. Altin SV, Finke I, Kautz-Freimuth S, Stock S. The evolution of health literacy assessment tools: a
35 systematic review. *BMC Public Health* 2014;**14**:1207. doi: 10.1186/1471-2458-14-1207.
36
37
38 17. Haun JN, Valerio MA, McCormack LA, *et al*. Health literacy measurement: an inventory and
39 descriptive summary of 51 instruments. *J Health Commun* 2014;**19**:302-33. doi:
40 10.1080/10810730.2014.936571.
41
42
43
44
45 18. Jordan JE, Osborne RH, Buchbinder R. Critical appraisal of health literacy indices revealed variable
46 underlying constructs, narrow content and psychometric weaknesses. *J Clin Epidemiol* 2011;**64**:366-
47 79. doi: 10.1016/j.jclinepi.2010.04.005.
48
49
50
51 19. Kiechle ES, Bailey SC, Hedlund LA, *et al*. Different measures, different outcomes? A systematic review
52 of performance-based versus self-reported measures of health literacy and numeracy. *J Gen Intern*
53 *Med* 2015;**30**:1538-46. doi: 10.1007/s11606-015-3288-4.
54
55
56
57
58
59
60

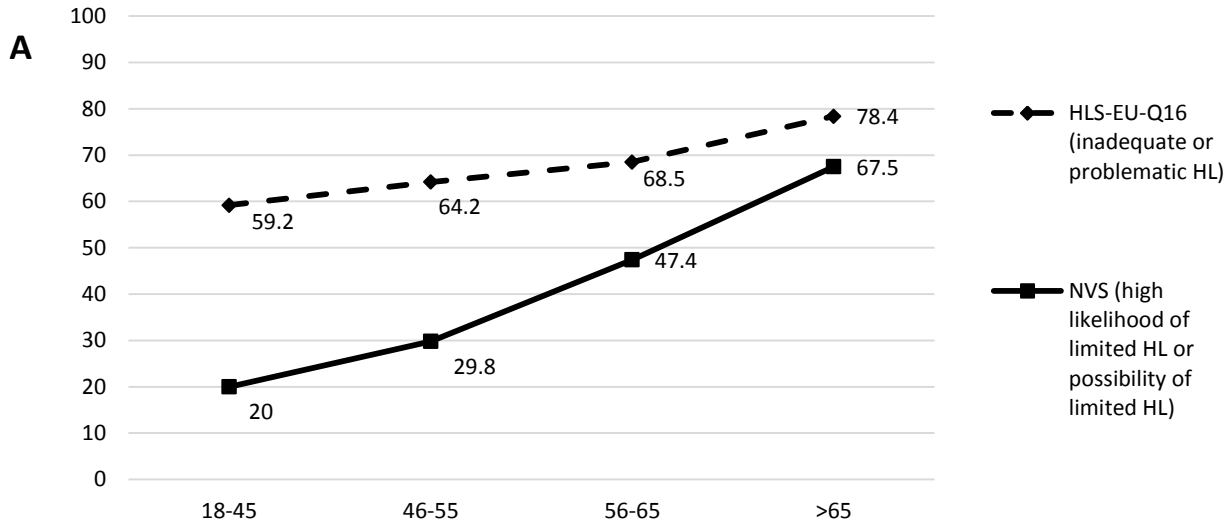
- 1
2
3 20. Marciano L, Camerini AL, Schulz PJ. The role of health literacy in diabetes knowledge, self-care, and
4
5 glycemic control: a meta-analysis. *J Gen Intern Med* 2019;**34**:1007-17. doi: 10.1007/s11606-019-
6
7 04832-y.
8
9
10 21. Malloy-Weir L, Cooper M. Health literacy, literacy, numeracy and nutrition label understanding and
11
12 use: a scoping review of the literature. *J Hum Nutr Diet* 2017;**30**:309-25. doi: 10.1111/jhn.12428.
13
14 22. Lorini C, Santomauro F, Donzellini M, *et al.* Health literacy and vaccination: a systematic review. *Hum*
15
16 *Vaccin Immunother* 2018;**14**:478-88. doi: 10.1080/21645515.2017.
17
18 23. Griffin JM, Partin MR, Noorbaloochi S, *et al.* Variation in estimates of limited health literacy by
19
20 assessment instruments and non-response bias. *J Gen Intern Med* 2010;**27**:675-81. doi:
21
22 10.1007/s11606-010-1304-2.
23
24 24. Pleasant A, McKinney J, Rikard RV. Health Literacy measurement: a proposed research agenda. *J*
25
26 *Health Commun* 2011;**16**:11-21. doi: 10.1080/10810730.2011.604392.
27
28 25. McCormack L, Haun J, Sørensen K, *et al.* Recommendations for advancing health literacy
29
30 measurement. *J Health Commun* 2013;**18**:9-14. doi: 10.1080/10810730.2013.829892.
31
32 26. Almaleh R, Helmy Y, Farhat E, *et al.* Assessment of health literacy among outpatient clinics attendees
33
34 at Ain Shams University Hospitals. Egypt: a cross-sectional study. *Public Health* 2017;**151**:137-45. doi:
35
36 10.1016/j.puhe.2017.06.024.
37
38 27. Pelikan JM, Ganahl K. Measuring health literacy in general populations: primary findings from the
39
40 HLS-EU Consortium's Health Literacy Assessment Effort. *Stud Health Technol Inf* 2017;**240**:34-59. doi:
41
42 10.3233/978-1-61499-790-0-34.
43
44 28. Waters EA, Biddle C, Kaphingst KA, *et al.* Examining the interrelations among objective and subjective
45
46 health literacy and numeracy and their associations with health knowledge. *J Gen Intern Med*
47
48 2018;**33**:1945-53. doi: 10.1007/s11606-018-4624-2.
49
50 29. Lorini C, Santomauro F, Grazzini M, *et al.* Health literacy in Italy: a cross-sectional study protocol to
51
52 assess the health literacy level in a population-based sample and to validate health literacy measures
53
54 in the Italian language. *BMJ Open* 2017;**7**: 017812. doi: 10.1136/bmjopen-2017-017812.
55
56
57
58
59
60

- 1
2
3 30. Lorini C, Lastrucci V, Mantwill S, *et al.* Measuring health literacy in Italy: a validation study of the HLS-
4 EU-Q16 and of the HLS-EU-Q6 in Italian language, conducted in Florence and its surroundings. *Ann*
5 *Ist Super Sanita* 2019;**55**:10-8. doi: 10.4415/ANN_19_01_04.
6
7
8
9
10 31. Bechini A, Pieralli F, Chellini E, *et al.* Application of socio-economic-health deprivation index, analysis
11 of mortality and influenza vaccination coverage in the elderly population of Tuscany. *J Prev Med Hyg*
12 2019;**59**(4 Suppl 2): E18–E25. <https://doi.org/10.15167/2421-4248/jpmh2018.59.4s2.1116>
13
14
15
16 32. Unim B, De Vito C, Massimi A, *et al.* The need to improve implementation and use of lifestyle
17 surveillance systems for planning prevention activities: an analysis of the Italian Regions. *Public*
18 *health* 2016;**130**:51-58.
19
20
21
22
23 33. Minardi V, Ferrante G, D’Argenio P, *et al.* Roll-your-own cigarette use in Italy: sales and consumer
24 profile—data from PASSI surveillance, 2015–2016. *Int J Public Health* 2019;**64**(3): 423-430.
25
26
27
28 34. Capecchi L, Guazzini A, Lorini C, *et al.* The first Italian validation of the most widespread health literacy
29 assessment tool: the Newest Vital Sign. *Epidemiol Prev* 2015;**39**: 124–8.
30
31
32 35. Bonaccorsi G, Pieralli F, Innocenti M, *et al.* Non-familial paid caregivers as potential flu carriers and
33 cause of spread: the primary prevention of flu measured through their adhesion to flu vaccination
34 campaigns - A Florentine experience. *Hum Vaccin Immunother* 2019;**2**:1-7. doi:
35 10.1080/21645515.2019.1593726.
36
37
38
39
40 36. Bonaccorsi G, Grazzini M, Pieri L, *et al.* Assessment of Health Literacy and validation of single-item
41 literacy screener (SILS) in a sample of Italian people. *Ann Ist Super Sanita* 2017;**53**:205–12. doi:
42 10.4415/ANN_17_03_05.
43
44
45
46
47 37. Weiss BD, Mays MZ, Martz W, *et al.* Quick Assessment of Literacy in Primary Care: The Newest Vital
48 Sign. *Ann Fam Med* 2005;**3**(6):514-22.
49
50
51
52 38. Sørensen K, Pelikan JM, Röthlin F, *et al.* Health literacy in Europe: comparative results of the
53 European health literacy survey (HLS-EU). *Eur J Public Health* 2015;**25**:1053-8. doi:
54 10.1093/eurpub/ckv043.
55
56
57
58
59
60

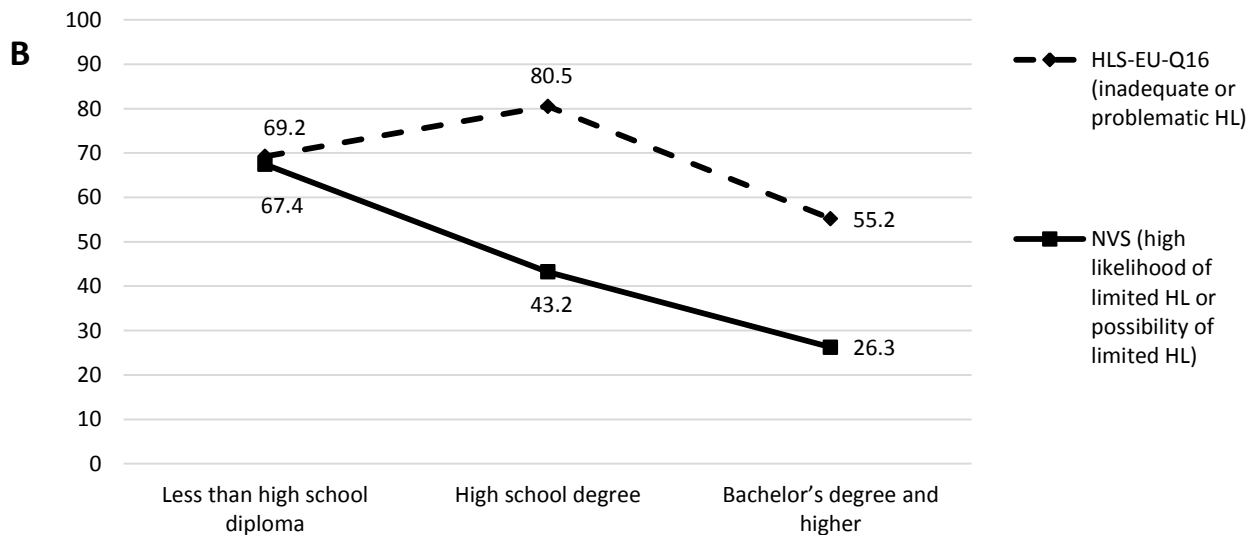
- 1
2
3 39. Sørensen K, Van den Broucke S, Pelikan JM, *et al.* Measuring health literacy in populations:
4
5 illuminating the design and development process of the European Health Literacy Survey
6
7 Questionnaire (HLS-EU-Q). *BMC Public Health* 2013;**13**: 948. doi: 10.1186/1471-2458-13-948.
8
9
- 10 40. Halbach SM, Ernstmann N, Kowalski C, *et al.* Unmet information needs and limited health literacy in
11
12 newly diagnosed breast cancer patients over the course of cancer treatment. *Patient Educ Couns*
13
14 2016;**99**:1511-18. doi: 10.1016/j.pec.2016.06.028.
15
16
- 17 41. Pelikan JM, Ganahl K. Measuring health literacy in general populations: primary findings from the
18
19 HLS-EU Consortium's health literacy assessment effort. *Stud Health Technol Inform* 2017;**240**:34-59.
20
21
- 22 42. Koletsi D, Pandis N. Ordinal logistic regression. *Am J Orthod Dentofacial Orthop* 2018;**153**:157-8. doi:
23
24 10.1016/j.ajodo.2017.11.011.
25
26
- 27 43. Fransen MP, Leenaars KE, Rowlands G, *et al.* International application of health literacy measures:
28
29 adaptation and validation of the newest vital sign in The Netherlands. *Patient Educ Couns*
30
31 2014;**97**:403-9. doi: 10.1016/j.pec.2014.08.017.
32
33
- 34 44. Alba JW. Knowledge calibration what consumers know and what they think they know. *J Consum Res*
35
36 2000;**72**:123-65. <https://doi.org/10.1086/314317>.
37
38
- 39 45. Carlson JP, Vincent LH, Hardesty DM, *et al.* Objective and subjective knowledge relationships: a
40
41 quantitative analysis of consumer research findings. *J Consum Res* 2009;**35**:864-76.
42
43 <https://doi.org/10.1086/593688>.
44
45
- 46 46. Pieniak S, Aertsens J, Verbeke W. Subjective and objective knowledge as determinants of organic
47
48 vegetables consumption. *Food Qual Preference* 2010;**21**:581-88.
49
50 <https://doi.org/10.1016/j.foodqual.2010.03.004>.
51
52
- 53 47. Schinckus L, Dangoisse F, Van den Broucke S, *et al.* When knowing is not enough: emotional distress
54
55 and depression reduce the positive effects of health literacy on diabetes self-management. *Patient*
56
57 *Educ Couns* 2018;**101**:324-30. doi: 10.1016/j.pec.2017.08.006.
58
59
60

- 1
2
3 48. Stolp S, Zabrocky KM. Contributions of metacognitive and self-regulated learning theories to
4 investigations of calibration of comprehension. *International Electronic Journal of Elementary*
5 *Education* 2017;**2**:7-31.
6
7
8
9
10 49. Belmi P, Neale MA, Reiff D. *et al*. The social advantage of miscalibrated individuals: the relationship
11 between social class and overconfidence and its implications for class-based inequality. *J Pers Soc*
12 *Psychol* (2019). doi: 10.1037/pspi0000187
13
14
15
16 50. Crondahl K, Karlsson LE. The nexus between health literacy and empowerment: a scoping review.
17 *Sage Open* 2016;**6**:1-7. <https://doi.org/10.1177/2158244016646410>
18
19
20
21 51. Nutbeam D. Health literacy as a public health goal: a challenge for contemporary health education
22 and communication strategies into the 21st century. *Health Prom Intern* 2000;**15**:259-67.
23 <https://doi.org/10.1093/heapro/15.3.259>.
24
25
26
27 52. Chinn D. Critical health literacy: a review and critical analysis. *Soc Sci Med* 2011;**73**:60-7. doi:
28 10.1016/j.socscimed.2011.04.004.
29
30
31
32 53. Van der Heide I, Heijmans M, Schuit AJ, *et al*. Functional, interactive and critical health literacy:
33 varying relationships with control over care and number of GP visits. *Patient Educ Couns*
34 2015;**98**:998-1004. doi: 10.1016/j.pec.2015.04.006.
35
36
37
38 54. Fletcher RH, Fletcher SH, Fletcher Grant S. Clinical epidemiology: the essentials, fifth ed., Lippincott
39 Williams & Wilkins, Philadelphia 2012.
40
41
42
43 55. United States Government, Office of Disease Prevention and Health Promotion, Office of the
44 Assistant Secretary for Health, Office of the Secretary, Department of Health and Human Services.
45 Solicitation for Written Comments on an Updated Health Literacy Definition for Healthy People 2030.
46 Available at: [https://www.federalregister.gov/documents/2019/06/04/2019-11571/solicitation-for-](https://www.federalregister.gov/documents/2019/06/04/2019-11571/solicitation-for-written-comments-on-an-updated-health-literacy-definition-for-healthy-people-2030)
47 [written-comments-on-an-updated-health-literacy-definition-for-healthy-people-2030](https://www.federalregister.gov/documents/2019/06/04/2019-11571/solicitation-for-written-comments-on-an-updated-health-literacy-definition-for-healthy-people-2030).
48
49
50
51
52
53
54
55
56
57
58
59
60

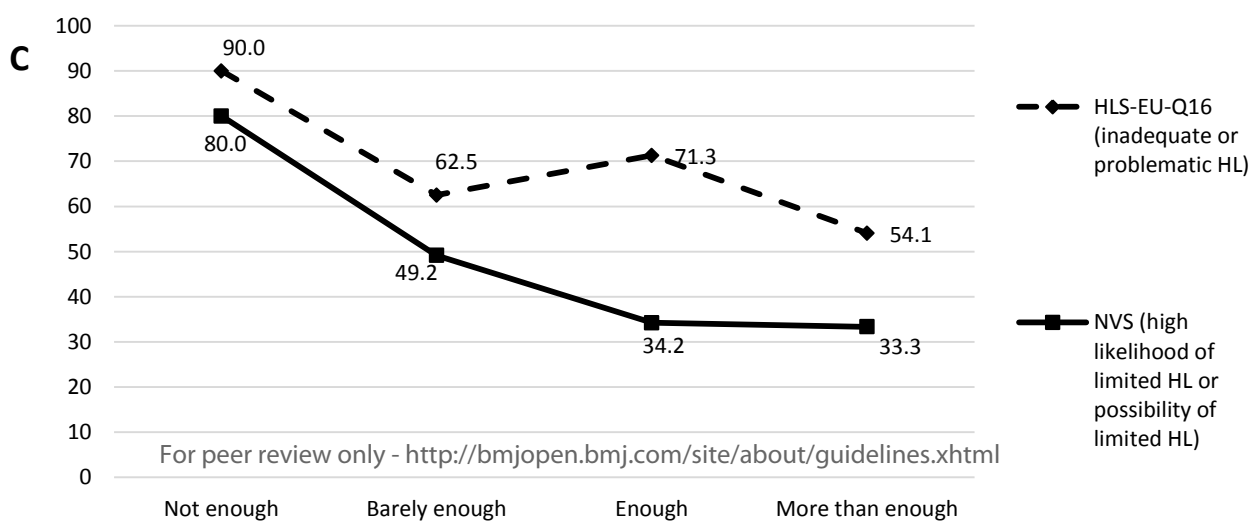
Low Health Literacy by age class (%)



Low Health Literacy by educational level (%)



Low Health Literacy by Financial resources (%)



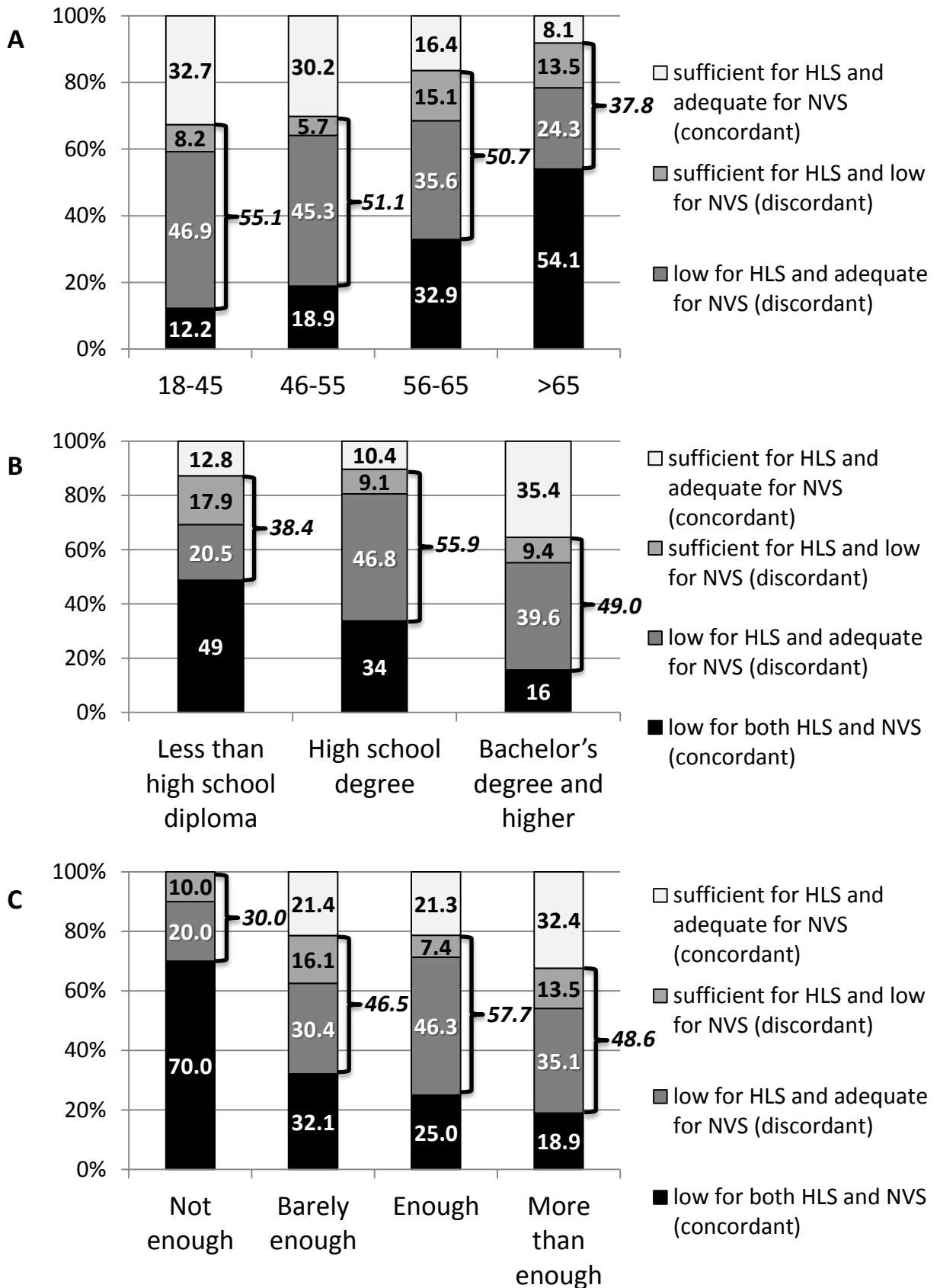


Table S1. Percentage of people with regards to the two health literacy measures (HLS-EU-Q16 and NVS) by age class, educational level, and financial resources.

CI= Confidence Interval.

Variables		HL level			
		Raw percentage (95% CI)			
		low for both HLS and NVS (concordant)	low for HLS and adequate for NVS (discordant)	sufficient for HLS and low for NVS (discordant)	sufficient for HLS and adequate for NVS (concordant)
Age	≤45	12.2% (4.6–24.8%)	46.9% (32.5–61.7%)	8.2% (2.3–19.6%)	32.7% (19.0–47.5%)
	46–55	18.9% (9.4–32%)	45.3% (31.6–59.6%)	5.7% (1.2–15.7%)	30.2% (18.3–44.3%)
	56–65	32.9% (22.3–44.9%)	35.6% (24.7–47.7%)	15.1% (7.8–25.4%)	16.4% (8.8–27.0%)
	>65	54.1% (36.9–70.5%)	24.3% (11.8–41.2%)	13.5% (4.5–28.8%)	8.1% (1.7–21.9%)
Educational level	Less than high school diploma	48.7% (32.4–65.2%)	20.5% (9.3–36.5%)	17.9% (7.5–33.5%)	12.8% (4.3–27.4%)
	High school degree	33.8% (23.4–45.4%)	46.8% (35.3–58.5%)	9.1% (3.7–17.8%)	10.4% (4.6–19.4%)
	Bachelor's degree and higher	15.6% (9–24.5%)	39.6% (29.7–50.1%)	9.4% (4.4–17.1%)	35.4% (25.9–45.8%)
Financial resources at disposal from own or family income enough to get to the end of the month	Not enough	70.0% (34.8–93.3%)	20.0% (2.5–55.6%)	10.0% (0.3–44.5%)	0% (0–30.8%)
	Barely enough	32.1% (20.3–40%)	30.4% (18.8–44.1%)	16.1% (7.6–28.3)	21.4% (11.6–34.4%)
	Enough	25.0% (17.2–34.3%)	46.3% (36.7–56.2%)	7.4% (3.3–14.1%)	21.3% (14–30.2%)
	More than enough	18.9% (8–35.2%)	35.1% (20.2–52.5%)	13.5% (4.5–28.8%)	32.4% (18–49.8%)

STROBE 2007 (v4) Statement—Checklist of items that should be included in reports of cross-sectional studies

Section/Topic	Item #	Recommendation	Reported on page #
Title and abstract	1	(a) Indicate the study's design with a commonly used term in the title or the abstract	
		(b) Provide in the abstract an informative and balanced summary of what was done and what was found	2
Introduction			
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported	4; 5
Objectives	3	State specific objectives, including any prespecified hypotheses	5
Methods			
Study design	4	Present key elements of study design early in the paper	6
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection	6
Participants	6	(a) Give the eligibility criteria, and the sources and methods of selection of participants	6
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable	6; 7; 8
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group	6;7; 8
Bias	9	Describe any efforts to address potential sources of bias	8
Study size	10	Explain how the study size was arrived at	5;6
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why	8
Statistical methods	12	(a) Describe all statistical methods, including those used to control for confounding	8
		(b) Describe any methods used to examine subgroups and interactions	8
		(c) Explain how missing data were addressed	
		(d) If applicable, describe analytical methods taking account of sampling strategy	
		(e) Describe any sensitivity analyses	
Results			

Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed	9
		(b) Give reasons for non-participation at each stage	9
		(c) Consider use of a flow diagram	
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders	9; 10
		(b) Indicate number of participants with missing data for each variable of interest	17
Outcome data	15*	Report numbers of outcome events or summary measures	9; 10; 11
Main results	16	(a) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included	19; 20
		(b) Report category boundaries when continuous variables were categorized	17; 18; 19; 20
		(c) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period	
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses	
Discussion			
Key results	18	Summarise key results with reference to study objectives	11
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias	13
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence	12; 13
Generalisability	21	Discuss the generalisability (external validity) of the study results	12; 13
Other information			
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based	14

*Give information separately for cases and controls in case-control studies and, if applicable, for exposed and unexposed groups in cohort and cross-sectional studies.

Note: An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at <http://www.plosmedicine.org/>, Annals of Internal Medicine at <http://www.annals.org/>, and Epidemiology at <http://www.epidem.com/>). Information on the STROBE Initiative is available at www.strobe-statement.org.

BMJ Open

**Measuring health literacy combining by performance-based and self-assessed measures.
The roles of age, educational level, and financial resources in predicting health literacy skills: a cross-sectional study conducted in Florence (Italy)**

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2019-035987.R2
Article Type:	Original research
Date Submitted by the Author:	27-Jul-2020
Complete List of Authors:	Lorini, Chiara; University of Florence, Department of Health Sciences Lastrucci, Vieri; University of Florence, Department of Health Sciences Paolini, Diana; University of Florence, Department of Health Sciences Research Group, Florence Health Literacy ; University of Florence, Department of Health Sciences Bonaccorsi, Guglielmo; University of Florence, Department of Health Sciences
Primary Subject Heading:	Public health
Secondary Subject Heading:	Research methods
Keywords:	PUBLIC HEALTH, PREVENTIVE MEDICINE, STATISTICS & RESEARCH METHODS

SCHOLARONE™
Manuscripts



I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our [licence](#).

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which [Creative Commons](#) licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

1
2
3 **Measuring health literacy combining by performance-based and self-assessed measures.**
4

5 **The roles of age, educational level, and financial resources in predicting health literacy skills: a**
6
7
8 **cross-sectional study conducted in Florence (Italy)**
9

10
11
12 Chiara Lorini¹, Vieri Lastrucci^{1*}, Diana Paolini¹, Florence Health Literacy Research Group[^], Guglielmo
13
14 Bonaccorsi¹
15
16

17
18
19 [^]Florence Health Literacy Research Group: Elisabetta Alti³, Sergio Baglioni³, Leonardo Bellino³, Niccolò Berzi³,
20
21 Jacopo Bianchi⁴, Guglielmo Bonaccorsi¹, Giuseppe Burgio³, Alessandro Bussotti⁵, Marco Del Riccio¹, Martina
22
23 Donzellini⁴, Angela Galdiero⁶, Alessandro Grassi³, Tommaso Grassi⁴, Vieri Lastrucci¹, Arrigo Lombardi³, Chiara
24
25 Lorini¹, Sarah Mantwill², Federico Manzi⁴, Alessandro Mereu³, Donatella Messina³, Chiara Milani⁴, Diana
26
27 Paolini¹, Marco Targonato³, Marco Toccafondi³, Gino Sartor⁴, Virginia Vettori¹
28
29
30

- 31
32
33 1. Department of Health Science, University of Florence, Florence, Italy
34
35 2. Department of Health Sciences & Health Policy, University of Lucerne, Lucerne, Switzerland
36
37 3. General Practitioner, Local Health Unit - Toscana Centro, Italy
38
39 4. School of Specialization in Hygiene and Preventive Medicine, University of Florence, Florence, Italy
40
41 5. Careggi University Hospital, Florence, Italy
42
43 6. Local Health Unit - Toscana Centro, Italy
44
45
46
47

48 *Corresponding author:
49

50 Vieri Lastrucci; e-mail: vieri.lastrucci@gmail.com; Postal address: Viale Morgagni, 48, 50134 Firenze, Italy
51
52
53
54
55
56
57
58
59
60

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Abstract

Objective

The objective was to compare the results of performance-based and self-assessed measures of health literacy (HL) and to evaluate the contribution of their joint use in assessing some HL antecedents.

Design

This was a cross-sectional study.

Setting

The study was conducted on the general population in Florence (Italy).

Participants

This study is part of a larger one, where participants were randomly selected from the registries of eleven general practitioners (GPs) working in the municipality of Florence. Inclusion criteria were the following: 18-69 years of age and Italian speaking. Exclusion criteria included cognitive impairment, severe psychiatric disease, or end-stage disease. In this paper, 212 adults were included.

Outcome measures

HL was measured using the European Health Literacy Survey Questionnaire (HLS-EU-Q16) and the Newest Vital Sign (NVS). The HL levels obtained by means of the two measurement tools were combined into a new variable that described three different levels of HL skills: low HL skills, partial HL skills, and high HL skills. Multivariate ordinal logistic regression analysis was performed to assess the predictive roles of age class, educational level, and financial resources with respect to HL skills.

Results

Twenty-two percent of the sample had high HL skills, 28.3% had low HL skills, and 49.5% had partial HL skills. Educational level, age class and financial resources were significantly associated with HL skills, with OR values being higher than those obtained using the NVS or the HLS-EU-Q16 individually.

Conclusion

1
2
3 The combination of the results obtained using the NVS and the HLS-EU-Q16 improves the understanding of
4
5 HL. The new variable generated by this combination could be considered as a different way to assess HL and
6
7 its multidimensional contents.
8
9

10 11 12 **Strengths and limitations of this study** 13 14

- 15
16
17 • In this study, for the first time, two different measures of health literacy (HL) were combined into a
18
19 new measure, called “HL skills”.
- 20
21
22 • The study design (sampling procedure, criteria for the combination of the HL measures) led to
23
24 limitations in the generalizability of the results.
- 25
26
27 • A different approach in combining the two measures could have led to different results.
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Introduction

Health literacy (HL) is a multidimensional concept¹ that deals with broader competences that are needed to communicate, navigate, and actively participate within modern health care systems and, more generally, with an individual's capacity to assess, understand, and use health information in different settings^{2,3}. The skills that compose HL can be classified into three different typologies: the practical application of literacy skills ranging from those needed to be able to function effectively in everyday situations (functional); the cognitive and literacy skills that can be used to actively participate in everyday activities and to apply new information to changing circumstances (interactive); and cognitive skills that can be applied to critically analyse information and exert greater control over life events and situations (critical literacy)⁴. All of these competences enable a person to navigate within three domains: healthcare, disease prevention, and health promotion². For these reasons, HL affects people's health, and it is now considered as one of the main determinants of health inequality; it is significantly related to age, educational level, and economic status⁵⁻⁸ and is suggested to partially mediate the effect of socioeconomic status on health-related outcomes^{9,10,11}. Moreover, HL can also be considered as the balance between individual skills and the demands and complexities of societal systems¹²; it is the combination of cognitive capacities, life experiences, knowledge, and opportunities^{13,14}.

To date, several different definitions of HL have been proposed in the literature; as a result, a considerable number of HL measurement tools have been developed by now. Although this variety of measures permits the use of specific tools for specific aims and target groups, it rises debate and poses some challenges. Indeed, more than 150 measures exist, but no "gold standard" measure has emerged until now. Furthermore, only a small number of instruments examine multiple types of HL (functional, interactive, and critical), while the majority deal solely with the functional component, with the risk of fragmentation. Apart from that, measurement tools may be classified as either performance-based (objective) or self-assessed (subjective), as they capture different aspects, for example, the objective ability to understand medical information versus the effect of emotional or motivational aspects on the decision-making process¹⁵⁻¹⁸. As a consequence of the

1
2
3 lack of a comprehensive approach to HL measurement, the use of different or fragmented HL measures leads
4
5 to difficulties in comparing and/or to incomplete results in terms of the HL level and related outcomes, as
6
7 well as to an increasing risk of misinterpreting the effectiveness of interventions aimed at improving HL¹⁹⁻²⁴.

8
9 Besides, while performance-based tools can be assumed to objectively measure HL regardless of a person's
10
11 environment, self-assessed ones can be considered to be more situation specific; for instance, emotional or
12
13 motivational aspects of the decision-making process are also the consequence of family, community, and
14
15 system support¹³.

16
17 For these reasons, many authors suggest measuring HL using different instruments at the same time, so as
18
19 to assess different skills, abilities, and competences that constitute such a multidimensional construct¹⁵⁻²⁵.

20
21 Nevertheless, research using performance-based (i.e., direct testing of competences) and self-assessed
22
23 (perception-based, i.e., self-reported abilities) measures of different dimensions and types of HL
24
25 simultaneously remains scarce, and the results of such studies are usually focused on highlighting the
26
27 inconsistencies between the two types of tests, without assessing their potential joint contribution to
28
29 measuring HL as a unique concept^{14,19,26,27}.

30
31 In a study conducted on patients affected by diabetes or colon cancer, Waters et al.²⁸ found that
32
33 performance-based and self-assessed HL measures represent related but independent constructs; they are
34
35 able to predict objective disease knowledge but not perceived disease knowledge in the same way. Due to
36
37 these results, the author concluded that performance-based and self-assessed measures of HL are not
38
39 interchangeable, although they tend to be consistent in categorizing patients into different levels of HL²⁸. To
40
41 the best of our knowledge, no studies adopting a similar approach to the analysis of the HL determinants
42
43 have been published as yet.

44
45 The aim of this study is to compare the results of performance-based and self-assessed measures of HL and
46
47 to evaluate the potential contribution of their joint use in assessing some HL antecedents (age and socio-
48
49 economical determinants) in a population-based sample. We believe that this is the first attempt to use the
50
51

1
2
3 information obtained by different HL measurement tools to get further insight into the knowledge about the
4
5 antecedents of HL.
6
7
8
9

10 **Methods**

11
12
13

14 This study is part of a larger one, conducted in a population-based sample in Florence, Italy, with the aim of
15
16 measuring the HL level and validating some HL measurement tools. The study design is described
17
18 elsewhere²⁹, as well as some of its results³⁰.
19
20
21
22

23 *Data collection*

24

25 The study adopted a cross-sectional design that was carried out in a population-based sample. Participants
26
27 were randomly selected from the registries of eleven general practitioners (GPs) working in the municipality
28
29 of Florence. The municipality of Florence is about 102 km² in size, with a population density of about 3500
30
31 inhabitants/km²; socio-economic and health deprivation data are described elsewhere³¹.
32
33

34 The sample size of the study was calculated considering the first aim of the larger study (i.e., to assess the
35
36 level of functional HL using the Newest Vital Sign (NVS) in a population sample in Florence, Italy), as described
37
38 elsewhere⁷, and it was equal to 480 participants.
39
40

41 The GPs were recruited using convenience criteria: all of the GPs from the municipality of Florence were
42
43 invited to join the study by both the Provincial Medical Council and the University Hospital of Florence.
44
45 According to the study protocol, the first eight who voluntarily joined the study were included and were
46
47 asked to select 80 subjects among those registered as patients using a simple random sampling method.
48
49 Since oversampling was not enough to reach the sample size of 480, three more GPs were included, with a
50
51 second random sample for the first eight. In Italy, every resident over the age of 18 has to be registered in a
52
53 general practice, and people are enrolled in the general practices according to their place of residence. This
54
55 sampling method was chosen with the aim of increasing the population participation rate, as the invitation
56
57 letter was jointly signed by the general practitioners and the researcher in charge of the study.
58
59
60

1
2
3 The sample was selected within each neighbourhood of the municipality of Florence, since the recruited
4
5 general practices were based in all the areas of Florence.
6

7 The inclusion criteria were the following: 18–69 years of age and Italian speaking (since the survey was
8
9 conducted in Italian). The inclusion criteria were defined according to those of the Italian behavioural risk
10
11 factor surveillance system PASSI (*Progressi delle Aziende Sanitarie per la Salute in Italia*)³². The exclusion
12
13 criteria included cognitive impairment, severe psychiatric disease, or end-stage diseases. Each GP verified
14
15 the inclusion and exclusion criteria when selecting the sample.
16
17

18 The larger study included two different arms (A and B) with different aims and questionnaires. Each subject
19
20 was randomly allocated to one of the two arms. To meet the specific aims of the present study, only the B
21
22 arm of the research was considered, since the short form (16 items) of the European Health Literacy Survey
23
24 Questionnaire (HLS-EU-Q16) was only administered in this arm, together with the Italian version of the
25
26 Newest Vital Sign (NVS-IT, hereinafter, NVS).
27
28

29 Data collection started in February 2017 and finished on 31 December 2017. Each selected subject was
30
31 contacted via postal mail. Subjects received an information sheet signed by the GP and the person in-charge
32
33 of the study, which included a short description of the study, an invitation to participate, and a consent form.
34
35 Participants were asked to sign the consent form and return it via mail to the researchers in charge. The mail
36
37 also contained the nutritional label of the NVS. After receipt of the signed consent forms, the subjects were
38
39 contacted for a computer-assisted telephone interview. If the consent form was not received within 2 weeks,
40
41 a follow-up phone call was made by the research group. The phone call served to clarify any questions and
42
43 to identify and support people having difficulty completing the consent form (i.e., due to reading difficulty).
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100
101
102
103
104
105
106
107
108
109
110
111
112
113
114
115
116
117
118
119
120
121
122
123
124
125
126
127
128
129
130
131
132
133
134
135
136
137
138
139
140
141
142
143
144
145
146
147
148
149
150
151
152
153
154
155
156
157
158
159
160
161
162
163
164
165
166
167
168
169
170
171
172
173
174
175
176
177
178
179
180
181
182
183
184
185
186
187
188
189
190
191
192
193
194
195
196
197
198
199
200
201
202
203
204
205
206
207
208
209
210
211
212
213
214
215
216
217
218
219
220
221
222
223
224
225
226
227
228
229
230
231
232
233
234
235
236
237
238
239
240
241
242
243
244
245
246
247
248
249
250
251
252
253
254
255
256
257
258
259
260
261
262
263
264
265
266
267
268
269
270
271
272
273
274
275
276
277
278
279
280
281
282
283
284
285
286
287
288
289
290
291
292
293
294
295
296
297
298
299
300
301
302
303
304
305
306
307
308
309
310
311
312
313
314
315
316
317
318
319
320
321
322
323
324
325
326
327
328
329
330
331
332
333
334
335
336
337
338
339
340
341
342
343
344
345
346
347
348
349
350
351
352
353
354
355
356
357
358
359
360
361
362
363
364
365
366
367
368
369
370
371
372
373
374
375
376
377
378
379
380
381
382
383
384
385
386
387
388
389
390
391
392
393
394
395
396
397
398
399
400
401
402
403
404
405
406
407
408
409
410
411
412
413
414
415
416
417
418
419
420
421
422
423
424
425
426
427
428
429
430
431
432
433
434
435
436
437
438
439
440
441
442
443
444
445
446
447
448
449
450
451
452
453
454
455
456
457
458
459
460
461
462
463
464
465
466
467
468
469
470
471
472
473
474
475
476
477
478
479
480
481
482
483
484
485
486
487
488
489
490
491
492
493
494
495
496
497
498
499
500
501
502
503
504
505
506
507
508
509
510
511
512
513
514
515
516
517
518
519
520
521
522
523
524
525
526
527
528
529
530
531
532
533
534
535
536
537
538
539
540
541
542
543
544
545
546
547
548
549
550
551
552
553
554
555
556
557
558
559
560
561
562
563
564
565
566
567
568
569
570
571
572
573
574
575
576
577
578
579
580
581
582
583
584
585
586
587
588
589
590
591
592
593
594
595
596
597
598
599
600
601
602
603
604
605
606
607
608
609
610
611
612
613
614
615
616
617
618
619
620
621
622
623
624
625
626
627
628
629
630
631
632
633
634
635
636
637
638
639
640
641
642
643
644
645
646
647
648
649
650
651
652
653
654
655
656
657
658
659
660
661
662
663
664
665
666
667
668
669
670
671
672
673
674
675
676
677
678
679
680
681
682
683
684
685
686
687
688
689
690
691
692
693
694
695
696
697
698
699
700
701
702
703
704
705
706
707
708
709
710
711
712
713
714
715
716
717
718
719
720
721
722
723
724
725
726
727
728
729
730
731
732
733
734
735
736
737
738
739
740
741
742
743
744
745
746
747
748
749
750
751
752
753
754
755
756
757
758
759
760
761
762
763
764
765
766
767
768
769
770
771
772
773
774
775
776
777
778
779
780
781
782
783
784
785
786
787
788
789
790
791
792
793
794
795
796
797
798
799
800
801
802
803
804
805
806
807
808
809
810
811
812
813
814
815
816
817
818
819
820
821
822
823
824
825
826
827
828
829
830
831
832
833
834
835
836
837
838
839
840
841
842
843
844
845
846
847
848
849
850
851
852
853
854
855
856
857
858
859
860
861
862
863
864
865
866
867
868
869
870
871
872
873
874
875
876
877
878
879
880
881
882
883
884
885
886
887
888
889
890
891
892
893
894
895
896
897
898
899
900
901
902
903
904
905
906
907
908
909
910
911
912
913
914
915
916
917
918
919
920
921
922
923
924
925
926
927
928
929
930
931
932
933
934
935
936
937
938
939
940
941
942
943
944
945
946
947
948
949
950
951
952
953
954
955
956
957
958
959
960
961
962
963
964
965
966
967
968
969
970
971
972
973
974
975
976
977
978
979
980
981
982
983
984
985
986
987
988
989
990
991
992
993
994
995
996
997
998
999
1000

1
2
3 Age was collected as a continuous variable and then grouped into four classes (18–45; 46–55; 56–65; >65
4 years old). Education was classified into three levels (less than high school diploma; high school degree;
5 bachelor’s degree and higher), while the financial status was investigated by the item “Is your income
6 adequate to meet monthly living expenses?” with four possible response options (not enough; barely
7 enough; enough; more than enough). This item was chosen since it is routinely used in the standardized
8 questionnaire of the Italian behavioural risk factor surveillance system PASSI³³.
9
10
11
12
13
14
15
16
17

18 *HL measures*

19
20
21 HL was measured using the NVS and the HLS-EU-Q16. The Italian version of the NVS was validated by
22 Capecchi et al. from the UK version³⁴, and then it was applied in many different contexts^{35,36}. It consists of an
23 ice cream nutrition label with seven associated questions that measure functional HL (prose and numeracy)
24 using a performance-based approach. It produces a final score ranging from 0 to 6, allowing participants to
25 be classified into three categories—high likelihood of limited HL (score: 0–1), possibility of limited HL (score:
26 2–3), and adequate HL (score: 4–6). These cut-off values were identified by Weiss et al. in a validation study
27 of the NVS, conducted in English-speaking and Spanish-speaking primary care patients, in which the HL
28 measured using the Test of Functional Health Literacy in Adults (TOFHLA) was considered as a reference³⁷.
29
30 The HL categories defined using the two cut off values (1 and 3) are widely used in many countries.
31
32 NVS data related to the entire sample of the study (A and B arms) have been described elsewhere⁷.
33
34
35
36
37
38
39
40
41
42

43 The European Health Literacy Survey was the first large population study aimed at generating first-time data
44 on HL across diverse populations in the European Union³⁸. To achieve this purpose, the European Health
45 Literacy Survey Questionnaire (HLS-EU-Q) for measuring HL was developed³⁹ on the basis of the
46 recommendations of Pleasant et al.²⁴ regarding the characteristics that a comprehensive measure of HL
47 should have. In particular, starting from the HLS-EU Consortium conceptual framework of HL², the HLS-EU-Q
48 assesses the processes of accessing, understanding, appraising, and applying health-related information
49 within the three domains of health: healthcare, disease prevention, and health promotion. It measures self-
50 assessed functional, critical, and interactive HL (i.e., general HL). The original full version of the HLS-EU-Q
51
52
53
54
55
56
57
58
59
60

1
2
3 comprises 47 items (HLS-EU-Q47), and the HLS-EU-Q16 is its short version that was developed by selecting
4
5 16 items²⁷. The HLS-EU-Q16 has Likert-type responses (“very easy”, “fairly easy”, “fairly difficult”, “very
6
7 difficult”) and an associated final score that measures interaction, comprehension, information seeking,
8
9 application/function, decision-making/critical thinking, evaluation, responsibility, confidence, and navigation
10
11 skills. To generate the score of the HLS-EU-Q16, the items are dichotomized into two categories with two
12
13 scores: “easy” (“fairly” or “very” easy = 1) and “difficult” (“fairly” and “very” difficult = 0). “Don’t
14
15 know/refusal” was recoded for missing answers. The scale score was calculated as the sum of the scores of
16
17 each item and varied between 0 and 16. As suggested by other studies^{26,40}, only respondents who gave an
18
19 answer to at least 14 items were considered. Three levels of HL were defined considering the HLS-EU-Q16
20
21 score: inadequate HL (0–8), problematic HL (9–12) and sufficient HL (13–16). The cut-off values for defining
22
23 the three levels were described by Pelikan et al. using the results of the European Health Literacy Survey,
24
25 with respect to the results obtained using the HLS-EU-Q47⁴¹, and then have been widely used.
26
27
28 As previously described, the Italian version of the HLS-EU-Q16 was validated in this study³⁰.

34 *Statistical analysis*

35
36 The Fisher exact test was used to evaluate associations between categorical variables.

37
38 A new HL measure, named “HL skills”, was defined by combining the results obtained using the two tests
39
40 (HLS-EU-Q16 and NVS). The criterion used for combining the two measures was a simple approach that
41
42 allowed to different levels of skills to be identified. In particular, the variable was created as follows:
43
44

- 45 1) “low HL skills” level that comprises a high likelihood or possibility of limited HL measured by NVS and
46
47 inadequate or problematic HL measured by HLS-EU-Q16;
 - 48 2) “partial HL skills” level that comprises a high likelihood or possibility of limited HL measured by NVS
49
50 and sufficient HL measured by HLS-EU-Q16 or, conversely, adequate HL measured by NVS and
51
52 inadequate or problematic HL according to HLS-EU-Q16;
 - 53 3) “high HL skills” level that comprises adequate HL measured by NVS and sufficient HL measured by
54
55 HLS-EU-Q16.
- 56
57
58
59
60

1
2
3 The subjects classified among those with “low HL skills” presented some limitations in both functional and
4 general HL; those with “partial HL skills” presented some limitation either in functional or in general HL; while
5 those with “high HL skills” presented the highest level of HL skills in both functional and general HL.
6
7
8

9
10 A multivariate ordinal logistic regression analysis⁴² was performed to assess the predictive roles of age class,
11 educational level, and financial resources with respect to “HL skills”. Specifically, “HL skills” was the
12 dependent ordinal variable while age class, educational level, and financial resources were the independent
13 ordinal variables (covariates). In ordinal logistic regression model, the predictive role is expressed as the
14 proportional odds ratio (OR), and it can be interpreted in the same way as ORs are interpreted for the
15 conventional logistic regression for binary outcomes. The OR obtained from this model was a measure of the
16 change in the odds from lower to higher levels, i.e., from lower to higher HL skills. As a comparison, the same
17 multivariate ordinal logistic regression analysis was applied considering the level of HL measured by each
18 single HL test (i.e., NVS and HLS-EU-Q16) as a dependent ordinal variable. Specifically, two models were
19 developed: in the first one, the NVS level was the dependent variable (1—high likelihood of limited HL; 2—
20 possibility of limited HL; 3—adequate HL), while in the second one, the HLS-EU-Q16 level was the dependent
21 variable (1—inadequate HL; 2—problematic HL; 3—sufficient HL).
22
23
24
25
26
27
28
29
30
31
32
33
34
35

36 Statistical analyses were conducted using Stata version 15 (Stata Corp, College Station, TX). All tests were
37 two-sided, and p-values were considered to be statistically significant when below 0.05.
38
39
40
41
42

43 *Patient and public involvement*

44
45 The study population was not directly involved in the design, recruitment, and conduct of this study.
46 However, the Florence Health Literacy Research Group involved representatives from the Provincial Medical
47 Council, Local Health Unit, and University Hospital of Florence. All of these representatives were involved in
48 the study design and questionnaire development and will disseminate the results from this work.
49
50
51
52
53
54
55

56 **Results**

1
2
3 The refusal rate was 15.6%, while 38.2% of the invited people did not respond to any contact attempts and
4 were considered unreachable. Finally, 212 subjects (58% females; mean age: 53.6 ±11.9 years) were
5 interviewed for the purpose of this study. The majority of them (96.7%) were Italian, with a high school
6 (36.3%) or university (45.3%) degree, and had enough or more than enough financial resources at their
7 disposal from their own or family income to get to the end of the month (68.3%) (Table 1).
8
9

10
11
12
13
14 According to the HLS-EU-Q16, 11.8% had inadequate, 55.2% had problematic, and 33% had sufficient HL;
15 considering the NVS, 10.4% had a high likelihood of having limited HL, 28.8% had a possibility of having
16 limited HL, and 60.8% had adequate HL (Table 1).
17
18

19
20 As for NVS, the HL levels were significantly ($p < 0.05$) associated with age class, educational level, and financial
21 resources, while when measured by HLS-EU-Q16, the HL levels were significantly ($p < 0.05$) associated only
22 with education. The percentage of people with low HL was higher when it was measured by HLS-EU-Q16 than
23 for NVS in each category of age class, educational level, and financial resources (Figure 1). For both measures,
24 the percentage of people with low HL increased with age and became more similar in older people: for HLS-
25 EU-Q16, it ranged from 59.2% for those aged 18–45 to 78.4% for those >65 years old; for NVS, it ranged from
26 20% for those aged 18–45 to 67.5% for those aged >65 years old. Similar results were observed for
27 educational level and financial resources: for both tests, the percentage of people with low HL increased with
28 a decrease in educational level or financial resources; in the lowest sub-categories (i.e., less than high school
29 diploma or not having enough financial resources), the percentage of people with low HL became similar
30 between the two tests.
31
32

33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
Combining the classifications of both tests (Table 2), 22% of the sample had adequate levels of functional
(measured by NVS) and sufficient general HL (measured by HLS-EU-Q16). On the other hand, 28.3%
presented both low functional HL (high likelihood or possibility of limited HL measured by NVS) and low
general HL (inadequate or problematic HL according to HLS-EU-Q16). However, a greater part of the sample
(49.5%) presented inconsistent HL measurements with low functional HL and sufficient general HL or vice
versa. In particular, the percentage of participants with adequate functional HL and low general HL (38.7%)
was higher than the percentage of participants with low functional HL and sufficient general HL (10.8%).

1
2
3 The classification of the subjects into four HL groups (combining the two HL measures) was significantly
4 associated with age class, educational level, and financial resources (Figure 2; Table S1). With an increase in
5 age, the percentage of people with adequate HL for NVS and sufficient HL for HLS-EU-Q16 decreased; the
6 percentage was similar between the 18–45 and 46–55 year-old age groups (about 30%), it halved in the 56–
7 65 year-old age group, and it halved again in the over 65 year-old age group. A similar tendency, although
8 less markedly evident, was observed for those with sufficient HL for HLS-EU-Q16 and low HL for NVS. At the
9 same time, the percentage of subjects with low HL for both tests increased with increasing age, ranging from
10 12.2% in the youngest age group to 54.1% in the oldest age group. Regarding education, with an increase in
11 the education level, there was a decrease in the percentage of people with low HL in both tests. The highest
12 percentage of subjects with adequate HL at NVS and sufficient HL at HLS-EU-Q16 was in the bachelor's degree
13 and higher group (35.4%), while the lowest percentage was registered in the high school degree group
14 (10.4%); the latter education group also presented the lowest percentage of people with sufficient HL at HLS-
15 EU-Q16 and low HL at NVS (9.1%) and the highest percentage of those with low HL at HLS-EU-Q16 and
16 adequate HL at NVS (46.8%). Moreover, with the increase in the availability of financial resources, the
17 percentage of people with adequate HL at NVS and sufficient HL at HLS-EU-Q16 increased, and, at the same
18 time, the percentage of people with low HL in both tests decreased; in particular, the percentage of people
19 with low HL in both tests halved, moving from the category “not enough” to “barely enough” (from 70% to
20 32.1%). Finally, in the more “disadvantaged” groups (elderly people, low educational level, not enough
21 availability of financial resources), the percentage of people with discordant results regarding the HL level
22 (i.e., low functional HL and sufficient general HL or vice versa) was lower than that obtained in the other
23 groups.

24
25 Considering the results of the multivariate ordinal regression model, all categories of the covariates showed
26 significant associations with the outcome, with the exception of “high school degree”, with an evident trend.
27 Moreover, OR values were greater than 3 in most cases (Table 3). In particular, the odds of having high HL
28 skills were higher as age decreased (OR value from 2.36 for 56–65 years old, to 5.14 for 18–45 years old),
29 financial resources increased (OR value from 5 for “barely enough” resources, to 8.65 for “more than enough”
30

resources), and for those with a bachelor's degree or higher (OR = 3.72). Table 4 reported the results of the same analyses conducted considering the level of HL as a dependent variable in accordance with the NVS (I model) and the HLS-EU-Q16 (II model). Considering the first model, functional HL significantly increased as age decreased (for those 46–55 years old: OR = 5.84; for those 18–45 years old: OR = 7.17) and for people with a bachelor's degree or higher (OR = 3.78), while financial resources did not show a predictive role. Regarding the second model, age class, educational level, and financial resources were not significantly associated with general HL.

Discussion

The aim of the study was to compare two different measures of HL and to evaluate the potential contribution of their joint use in assessing HL antecedents in a population-based sample. Our results showed that NVS and HLS-EU-Q16 led to results that did not completely overlap, as a relevant proportion of the population presented different HL levels when measured with different tools. Furthermore, the antecedents of HL investigated in this study have different weights in predicting NVS or HLS-EU-Q16 results. These results indicate that they measure different aspects of HL; these findings are in line with other studies conducted in other countries^{14,43}.

A possible explanation for these findings may lay in the nature of the two HL measurement tools, as the HLS-EU-Q16 is a self-assessed measure for general HL, while NVS is a performance-based measure of reading, understanding, and numeracy skills. In fact, what people think they know does not always correspond to what they actually know: people tend to be overconfident (they think they know more than they actually do) or underconfident (they think they know less than they actually do). Overconfidence and underconfidence are a consequence of the matching between knowledge, confidence, self-efficacy, and emotional distress⁴³⁻⁴⁷, and they may differ from country to country, as they are also influenced by cultural factors^{48,49}.

On the other hand, high skills in reading and understanding health related information (functional HL) do not necessarily imply high critical and interactive competencies (included in general HL), as these are also related

1
2
3 to problem-solving skills, life experiences, and empowerment^{50,51}. In fact, HL could also act as a balance
4
5 between individual skills and the demands and complexities of societal systems¹². Since it represents the
6
7 combination of cognitive capacities, life experiences, knowledge, and opportunities^{13,14}, it can be influenced
8
9 by the social environment in which it is assessed; this feature should and could be considered to tailor
10
11 interventions aimed at increasing its levels.
12

13
14 The simultaneous use of the two HL measures highlights the presence of three distinct HL groups in the
15
16 population. A first group is represented by the participants with an adequate level of functional and sufficient
17
18 general HL; this group has a broader range of HL skills (high HL skills) that can be used to participate actively
19
20 in everyday situations, extract health information, and derive meaning from different forms of health
21
22 communication. This can be applied to changing circumstances, to exert control over their care, and so
23
24 on^{52,53}. A second group is represented by the participants that presented with both low functional HL and
25
26 low general HL. These subjects lack a wide range of HL skills (low HL skills). Lastly, between these two
27
28 opposing conditions, a third group (partial HL skills) is represented by about half of the sample and includes
29
30 all the participants that presented with inconsistent HL measurements with low functional HL and sufficient
31
32 general HL or vice versa; these people have some HL skills, but lack others.
33
34

35
36 As far as the demographic and socio-economic characteristics of the HL groups defined by the two HL
37
38 measures are concerned, it is interesting to note that the more vulnerable population groups (the older, less
39
40 educated, and poorer) presented lower levels of discrepancy in the results obtained with the two HL tools,
41
42 and in most of cases, these groups presented a low HL level for both measures. On the contrary, the youngest
43
44 participants (18–45 years), those with a high school degree and those with enough financial resources
45
46 presented the highest percentage of people with partial HL skills low functional HL and sufficient general HL
47
48 in most cases. There seems to be a social gradient in accessing, understanding, appraising, and applying
49
50 information that is useful for adopting appropriate behaviours in everyday life, and in this sense, HL reflects
51
52 the disadvantage suffered by the most deprived people regarding education and wealth.
53
54

55
56 Regarding the combination of the results obtained by applying the two HL measures into a new variable, i.e.,
57
58 HL skills, findings showed that the new variable strengthens the association between HL and the investigated
59
60

1
2
3 antecedents. Indeed, the comparison of the three models of multivariate ordinal logistic regression showed
4 that age, educational level, and financial resources significantly and independently predict HL skills, with OR
5 values generally being higher than those observed in the models that consider each single HL measure. These
6
7 results suggest that a broader evaluation of HL dimensions—obtained by integrating the NVS and the HLS-
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

However, further research is needed to confirm these results and to evaluate whether this approach will also better predict the association between HL and health-related outcomes.

Moreover, as widely described for diagnostic and screening tests⁵⁴, the use of parallel tests (i.e., two tests administered at the same time followed by subsequent combination of the results) results in an increase in sensitivity—in this case, the identification of people with low HL skills. For these reasons, the integration of different HL measures using an approach similar to the one used in this study may help to widen the narrow view resulting from the use of a single measure and may serve as the basis for the design of a more comprehensive measurement tool for HL. In this regard, it should be underlined that the approach of integrating different HL measures is in line with what has been suggested by Pleasant et al.²⁴ for the definition of a comprehensive measure of HL: multi-dimensional in content and methodology.

This study has several limitations. Some of them are related to the sampling procedure. In particular, one of the main limitations is that the data cannot be considered representative of the overall Italian or Florentine adult population since the population-based sample was obtained with a combination of convenience and probability sampling procedures. For this reason, the generalizability of the results to the entire Florentine population is limited. In fact, although participants were randomly selected from the registers of the GPs, the GPs were selected using convenience criteria, which may have introduced a selection bias. Additionally, results may have been influenced by a non-response bias. Particularly, many of the enrolled people had a high socio-economic level (45.3% had a bachelor's degree or higher and 17.4% had more than enough financial resources). These limits could influence an external comparison of the study results, since age,

1
2
3 educational level, and financial resources are determinants of HL. Sex was not included in the analysis since,
4
5 at the univariate analysis, it was not significantly associated with HL.
6
7
8
9

10 Other limitations are related to the cut-off values of both the NVS and the HLS-EU-Q16 that were used to
11
12 categorize the levels of HL. Although widely-used thresholds were applied, these cut-offs have not been
13
14 previously validated for the Italian population, since large population-based studies using the NVS and HLS-
15
16 EU-Q16 have not been performed yet. Moreover, some alternatives could have been considered for the
17
18 combination of the two variables. In particular, one of them could be the combination of the items of the
19
20 two measures into a single scale and assessing the reliability using the classic approach. The chosen
21
22 methodology is related to the aim of giving an initial, simple approach for assessing the possibility of
23
24 integrating different measures of HL, and this will be refined with future studies.
25
26
27
28
29

30 **Conclusion**

31
32
33
34 In conclusion, our findings suggest that the combination of the results obtained using a performance-based
35
36 measure of functional HL (the NVS) and a self-assessed measure of general HL (HLS-EU-Q16) may improve
37
38 the understanding of the HL skills of individuals and populations as well as the relationship between HL and
39
40 its antecedents. In addition, the new variable generated by this combination of different HL measures (HL
41
42 skills) may help to better identify people with low HL skills and could be considered as a new measure of HL
43
44 or, at least, a different way of assessing HL and its multidimensional contents. Although further studies are
45
46 needed to confirm our findings and to better define the potential of the combined use of different HL
47
48 measures, we think that this paper can be considered to be a starting point for a novel approach to the
49
50 investigation of HL, regardless of the limits of this research,.
51
52
53

54 Moreover, the results of our study seem to be in line with the evolution of HL proposed by The Secretary's
55
56 Advisory Committee on US National Health Promotion and Disease Prevention Objectives for Healthy People
57
58 2030: "Health literacy occurs when a society provides accurate health information and services that people
59
60

1
2
3 can easily find, understand, and use to inform their decisions and actions.” Nowadays, we should consider
4
5 HL to be a type of social competence and responsibility, and we should measure all its facets to make it a
6
7 discipline that can contribute to a higher level of clarity, accessibility, and actionability, so as to reduce
8
9 inequalities in health⁵⁵.

14 **Funding sources**

16 This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-
17
18 profit sectors

23 **Ethics approval**

25 The study was approved by the Ethics Committee of the ‘Area Vasta Centro’ (Local Health Unit of Tuscany-
26
27 Center, Careggi University Hospital and Meyer University Hospital; Ref. CEAVC: 10113, 01 December 2016).

32 **Author's contribution statement**

34 Chiara Lorini: conception and design of the study; analysis and interpretation of data; drafting and revision
35
36 of the manuscript.

38 Vieri Lastrucci: conception and design of the study; generation, collection, assembly and interpretation of
39
40 data; drafting and revision of the manuscript.

43 Diana Paolini: conception and design of the study; generation, collection, assembly and interpretation of
44
45 data; drafting and revision of the manuscript.

48 Guglielmo Bonaccorsi: conception and design of the study; interpretation of data; drafting and revision of
49
50 the manuscript.

52 Other component of the Florence Health Literacy Research Group: conception and design of the study;
53
54 generation, collection, assembly of data; drafting and revision of the manuscript.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Conflict of interest statement

The authors declare no conflict of interest.

Acknowledgments

The Authors want to thank the MDPI English editing service for the copyediting.

Data availability statement

The dataset generated and analysed during the current study is available from the corresponding author on reasonable request.

Figures and Tables

Figure 1. Percentage of people with low health literacy by age class (A), educational level (B), and financial resources (C).

Figure 2. Percentage of people with regards to the two health literacy measures (HLS-EU-Q16 and NVS) by age class (A), educational level (B), and financial resources (C). For each graph, $p < 0.05$ (Fisher exact test).

Table 1. Descriptive analysis of the collected data (N = 212).

Variables		N	%
Age class	18–45	49	23.1
	46–55	53	25.0
	56–65	73	34.4
	>65	37	17.5
Educational level	Less than high school diploma	39	18.4
	High school degree	77	36.3
	Bachelor's degree and higher	96	45.3
Financial resources at disposal from own or family income enough to get to the end of the month*	Not enough	10	4.7
	Barely enough	56	26.4
	Enough	108	50.9
	More than enough	37	17.4
NVS level	High likelihood of limited HL	22	10.4
	Possibility of limited HL	61	28.8
	Adequate HL	129	60.8
HLS-EU-Q16 levels	Inadequate HL	25	11.8
	Problematic HL	117	55.2
	Sufficient HL	70	33.0

*1 missing value. HL: health literacy; HLS-EU-Q16: European Health Literacy Survey Questionnaire; NVS:

Newest Vital Sign.

Table 2. Level of health literacy considering both measures (NVS and HLS-EU-Q16).

		NVS		Total
		High likelihood or possibility of limited HL	Adequate HL	
HLS-EU-Q16	Inadequate or problematic HL	60 (28.3%)	82 (38.7%)	142 (67%)
	Sufficient HL	23 (10.8%)	47 (22.2%)	70 (33%)
Total		83 (39.1%)	129 (60.9%)	212 (100%)

Table 3. Multivariate ordinal logistic regression model (N = 211). Dependent variable: HL skills, obtained combining the results of the two measures (HLS-EU-Q16 and NVS; “low HL skills”, “partial HL skills”, “high HL skills”). OR: Odds Ratio; SE: standard error; CI: Confidence Interval.

Variables		OR (95%CI)	P>z
Age class	>65	1	-
	56-65	2.36 (1.05–5.33)	0.038
	46-55	4.85 (2.01–11.71)	<0.001
	18-45	5.14 (2.10–12.54)	<0.001
Educational level	Less than high school diploma	1	-
	High school degree	1.33 (0.59–3.02)	0.486
	Bachelor’s degree and higher	3.72 (1.64–8.44)	0.002
Financial resources at disposal from own or family income enough to get to the end of the month	Not enough	1	-
	Barely enough	5.50 (1.19–25.36)	0.029
	Enough	5.57 (1.26–24.54)	0.023
	More than enough	8.65 (1.79–41.73)	0.007

LR $\chi^2(10) = 51.38$; Prob > $\chi^2 < 0.001$; Log likelihood = -193.35519 ; Pseudo R² = 0.1173

bmjopen-2019-0335987 on 5 October 2020. Downloaded from <http://bmjopen.bmj.com/> on April 18, 2024 by guest. Protected by copyright.

Table 4. Multivariate ordinal logistic regression models (N = 211). In the first model, dependent variable: NVS (three levels); in the second model, dependent variable: HLS-EU-Q16 (three levels). OR: Odds Ratio; SE: standard error; CI: Confidence Interval.

Variables		I model: NVS as dependent variable*		II model: HLS-EU-Q16 as dependent variable°	
		OR (95%CI)	P>z	OR (95%CI)	P>z
Age class	>65	1	-	-	-
	56–65	2.13 (0.96–4.70)	0.060	1.45 (0.66–3.18)	0.357
	46–55	5.84 (2.33–14.65)	<0.001	1.60 (0.66–3.73)	0.271
	18–45	7.17 (2.70–19.04)	<0.001	1.95 (0.88–4.61)	0.126
Educational level	Less than high school diploma	1	-	-	-
	High school degree	1.90 (0.86–4.17)	0.110	0.65 (0.30–1.42)	0.285
	Bachelor’s degree and higher	3.78 (1.70–8.42)	0.001	1.31 (0.62–2.83)	0.493
Financial resources at disposal from own or family income enough to get to the end of the month	Not enough	1	-	-	-
	Barely enough	1.76 (0.49–6.37)	0.386	2.31 (0.61–8.69)	0.215
	Enough	3.40 (0.97–11.94)	0.057	1.87 (0.54–6.71)	0.336
	More than enough	2.91 (0.73–11.64)	0.131	3.91 (0.98–15.60)	0.054

* LR chi2(10) = 50.6; Prob > chi2 < 0.001; Log likelihood = -163.36457; Pseudo R2 = 0.1341

° LR chi2(10) = 15.64; Prob > chi2 = 0.0479; Log likelihood = -192.14072; Pseudo R2 = 0.0391

References

1. Kickbusch IS. Health literacy: Addressing the health and education divide. *Health Promot Int* 2001;**16**:289–97. <https://doi.org/10.1093/heapro/16.3.289>.
2. Sørensen K, Van den Broucke S, Fullam J, *et al*. Consortium Health Literacy Project European. Health literacy and public health: a systematic review and integration of definitions and models. *BMC Public Health* 2012;**12**:80. doi: 10.1186/1471-2458-12-80.
3. Van den Broucke S. Health literacy: a critical concept for public health. *Arch Public Health* 2014;**72**: 10. doi: 10.1186/2049-3258-72-10.
4. Freebody P, Luke A. 'Literacies' programs: debates and demands in cultural context. *Prospect* 1990;**5**: 7-16.
5. Kickbusch I, Pelikan LM, Apfel F, *et al*. *Health literacy. The solid facts*. Copenhagen: World Health Organisation Regional Office for Europe, 2013.
6. Kobayashi L, Wardle J, Wolf MS, *et al*. Aging and functional health literacy: a systematic review and meta-analysis. *J Gerontol B Psychol Sci Soc Sci* 2016;**71**:445-57. doi: 10.1093/geronb/gbu161.
7. Bonaccorsi G, Lastrucci V, Vettori V, *et al*. Functional Health Literacy in a population-based sample in Florence: an assessment using the Newest Vital Sign. *BMJ Open* 2019;**9**:e026356. doi: 10.1136/bmjopen-2018-026356.
8. Adams RJ, Appleton SL, Hill CL, *et al*. Risks associated with low functional health literacy in an Australian population. *Med J Aust* 2009;**191**:530–4.
9. Stormacq C, Van den Broucke S, Wosinski J. Does health literacy mediate the relationship between socioeconomic status and health disparities? Integrative review. *Health Promot Int* 2018. doi: 10.1093/heapro/day062.
10. Pelikan JM, Ganahl K, Roethlin F. Health literacy as a determinant, mediator and/or moderator of health: empirical models using the European Health Literacy Survey dataset. *Glob Health Promot* 2018;**25**:57-66. doi: 10.1177/1757975918788300.

- 1
2
3 11. Lastrucci V, Lorini C, Caini S, *et al.* Health literacy as a mediator of the relationship between
4 socioeconomic status and health: A cross-sectional study in a population-based sample in Florence.
5 *PLoS One* 2019;**14**(12):e0227007. doi: 10.1371/journal.pone.0227007.
6
7
8
9
10 12. Parker R. Measuring health literacy: What? So what? Now what. In: *Measures of health literacy:*
11 *workshop summary*. Washington, DC: National Academies Press, 2009.
12
13
14 13. Levin-Zamir D, Leung AYM, Dodson S, Rowlands G. Health Literacy in Selected Populations:
15 Individuals, Families, and Communities From the International and Cultural Perspective. *Stud Health*
16 *Technol Inform* 2017;**240**:392-414.
17
18
19
20 14. HLS-EU Consortium. Comparative report on health literacy in eight EU member states. The European
21 health literacy survey HLS-
22 EU. 2012 [http://ec.europa.eu/chafea/documents/news/Comparative_report_on_health_literacy_i](http://ec.europa.eu/chafea/documents/news/Comparative_report_on_health_literacy_in_eight_EU_member_states.pdf)
23 [n_eight_EU_member_states.pdf](http://ec.europa.eu/chafea/documents/news/Comparative_report_on_health_literacy_in_eight_EU_member_states.pdf)
24
25
26
27
28
29
30 15. Nguyen TH, Paasche-Orlow MK, McCormack LA. The state of the science of health literacy
31 measurement. *Stud Health Technol Inform* 2017;**240**:17-33. doi: 10.3233/ISU-170827.
32
33
34 16. Altin SV, Finke I, Kautz-Freimuth S, Stock S. The evolution of health literacy assessment tools: a
35 systematic review. *BMC Public Health* 2014;**14**:1207. doi: 10.1186/1471-2458-14-1207.
36
37
38 17. Haun JN, Valerio MA, McCormack LA, *et al.* Health literacy measurement: an inventory and
39 descriptive summary of 51 instruments. *J Health Commun* 2014;**19**:302-33. doi:
40 10.1080/10810730.2014.936571.
41
42
43
44
45 18. Jordan JE, Osborne RH, Buchbinder R. Critical appraisal of health literacy indices revealed variable
46 underlying constructs, narrow content and psychometric weaknesses. *J Clin Epidemiol* 2011;**64**:366-
47 79. doi: 10.1016/j.jclinepi.2010.04.005.
48
49
50
51 19. Kiechle ES, Bailey SC, Hedlund LA, *et al.* Different measures, different outcomes? A systematic review
52 of performance-based versus self-reported measures of health literacy and numeracy. *J Gen Intern*
53 *Med* 2015;**30**:1538-46. doi: 10.1007/s11606-015-3288-4.
54
55
56
57
58
59
60

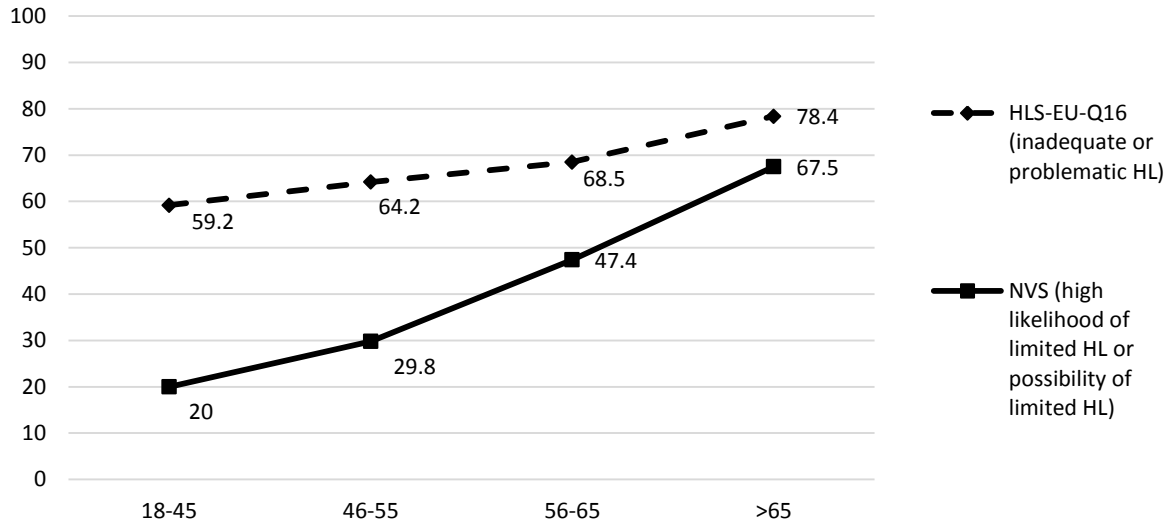
- 1
2
3 20. Marciano L, Camerini AL, Schulz PJ. The role of health literacy in diabetes knowledge, self-care, and
4
5 glycemic control: a meta-analysis. *J Gen Intern Med* 2019;**34**:1007-17. doi: 10.1007/s11606-019-
6
7 04832-y.
8
9
10 21. Malloy-Weir L, Cooper M. Health literacy, literacy, numeracy and nutrition label understanding and
11
12 use: a scoping review of the literature. *J Hum Nutr Diet* 2017;**30**:309-25. doi: 10.1111/jhn.12428.
13
14 22. Lorini C, Santomauro F, Donzellini M, *et al.* Health literacy and vaccination: a systematic review. *Hum*
15
16 *Vaccin Immunother* 2018;**14**:478-88. doi: 10.1080/21645515.2017.
17
18 23. Griffin JM, Partin MR, Noorbaloochi S, *et al.* Variation in estimates of limited health literacy by
19
20 assessment instruments and non-response bias. *J Gen Intern Med* 2010;**27**:675-81. doi:
21
22 10.1007/s11606-010-1304-2.
23
24 24. Pleasant A, McKinney J, Rikard RV. Health Literacy measurement: a proposed research agenda. *J*
25
26 *Health Commun* 2011;**16**:11-21. doi: 10.1080/10810730.2011.604392.
27
28 25. McCormack L, Haun J, Sørensen K, *et al.* Recommendations for advancing health literacy
29
30 measurement. *J Health Commun* 2013;**18**:9-14. doi: 10.1080/10810730.2013.829892.
31
32 26. Almaleh R, Helmy Y, Farhat E, *et al.* Assessment of health literacy among outpatient clinics attendees
33
34 at Ain Shams University Hospitals. Egypt: a cross-sectional study. *Public Health* 2017;**151**:137-45. doi:
35
36 10.1016/j.puhe.2017.06.024.
37
38 27. Pelikan JM, Ganahl K. Measuring health literacy in general populations: primary findings from the
39
40 HLS-EU Consortium's Health Literacy Assessment Effort. *Stud Health Technol Inf* 2017;**240**:34-59. doi:
41
42 10.3233/978-1-61499-790-0-34.
43
44 28. Waters EA, Biddle C, Kaphingst KA, *et al.* Examining the interrelations among objective and subjective
45
46 health literacy and numeracy and their associations with health knowledge. *J Gen Intern Med*
47
48 2018;**33**:1945-53. doi: 10.1007/s11606-018-4624-2.
49
50 29. Lorini C, Santomauro F, Grazzini M, *et al.* Health literacy in Italy: a cross-sectional study protocol to
51
52 assess the health literacy level in a population-based sample and to validate health literacy measures
53
54 in the Italian language. *BMJ Open* 2017;**7**: 017812. doi: 10.1136/bmjopen-2017-017812.
55
56
57
58
59
60

- 1
2
3 30. Lorini C, Lastrucci V, Mantwill S, *et al.* Measuring health literacy in Italy: a validation study of the HLS-
4 EU-Q16 and of the HLS-EU-Q6 in Italian language, conducted in Florence and its surroundings. *Ann*
5 *Ist Super Sanita* 2019;**55**:10-8. doi: 10.4415/ANN_19_01_04.
6
7
8
9
10 31. Bechini A, Pieralli F, Chellini E, *et al.* Application of socio-economic-health deprivation index, analysis
11 of mortality and influenza vaccination coverage in the elderly population of Tuscany. *J Prev Med Hyg*
12 2019;**59**(4 Suppl 2): E18–E25. <https://doi.org/10.15167/2421-4248/jpmh2018.59.4s2.1116>
13
14
15
16 32. Unim B, De Vito C, Massimi A, *et al.* The need to improve implementation and use of lifestyle
17 surveillance systems for planning prevention activities: an analysis of the Italian Regions. *Public*
18 *health* 2016;**130**:51-58.
19
20
21
22
23 33. Minardi V, Ferrante G, D’Argenio P, *et al.* Roll-your-own cigarette use in Italy: sales and consumer
24 profile—data from PASSI surveillance, 2015–2016. *Int J Public Health* 2019;**64**(3): 423-430.
25
26
27
28 34. Capecchi L, Guazzini A, Lorini C, *et al.* The first Italian validation of the most widespread health literacy
29 assessment tool: the Newest Vital Sign. *Epidemiol Prev* 2015;**39**: 124–8.
30
31
32 35. Bonaccorsi G, Pieralli F, Innocenti M, *et al.* Non-familial paid caregivers as potential flu carriers and
33 cause of spread: the primary prevention of flu measured through their adhesion to flu vaccination
34 campaigns - A Florentine experience. *Hum Vaccin Immunother* 2019;**2**:1-7. doi:
35 10.1080/21645515.2019.1593726.
36
37
38
39
40 36. Bonaccorsi G, Grazzini M, Pieri L, *et al.* Assessment of Health Literacy and validation of single-item
41 literacy screener (SILS) in a sample of Italian people. *Ann Ist Super Sanita* 2017;**53**:205–12. doi:
42 10.4415/ANN_17_03_05.
43
44
45
46
47 37. Weiss BD, Mays MZ, Martz W, *et al.* Quick Assessment of Literacy in Primary Care: The Newest Vital
48 Sign. *Ann Fam Med* 2005;**3**(6):514-22.
49
50
51
52 38. Sørensen K, Pelikan JM, Röthlin F, *et al.* Health literacy in Europe: comparative results of the
53 European health literacy survey (HLS-EU). *Eur J Public Health* 2015;**25**:1053-8. doi:
54 10.1093/eurpub/ckv043.
55
56
57
58
59
60

- 1
2
3 39. Sørensen K, Van den Broucke S, Pelikan JM, *et al.* Measuring health literacy in populations:
4
5 illuminating the design and development process of the European Health Literacy Survey
6
7 Questionnaire (HLS-EU-Q). *BMC Public Health* 2013;**13**: 948. doi: 10.1186/1471-2458-13-948.
8
9
- 10 40. Halbach SM, Ernstmann N, Kowalski C, *et al.* Unmet information needs and limited health literacy in
11
12 newly diagnosed breast cancer patients over the course of cancer treatment. *Patient Educ Couns*
13
14 2016;**99**:1511-18. doi: 10.1016/j.pec.2016.06.028.
15
16
- 17 41. Pelikan JM, Ganahl K. Measuring health literacy in general populations: primary findings from the
18
19 HLS-EU Consortium's health literacy assessment effort. *Stud Health Technol Inform* 2017;**240**:34-59.
20
21
- 22 42. Koletsi D, Pandis N. Ordinal logistic regression. *Am J Orthod Dentofacial Orthop* 2018;**153**:157-8. doi:
23
24 10.1016/j.ajodo.2017.11.011.
25
26
- 27 43. Fransen MP, Leenaars KE, Rowlands G, *et al.* International application of health literacy measures:
28
29 adaptation and validation of the newest vital sign in The Netherlands. *Patient Educ Couns*
30
31 2014;**97**:403-9. doi: 10.1016/j.pec.2014.08.017.
32
33
- 34 44. Alba JW. Knowledge calibration what consumers know and what they think they know. *J Consum Res*
35
36 2000;**72**:123-65. <https://doi.org/10.1086/314317>.
37
38
- 39 45. Carlson JP, Vincent LH, Hardesty DM, *et al.* Objective and subjective knowledge relationships: a
40
41 quantitative analysis of consumer research findings. *J Consum Res* 2009;**35**:864-76.
42
43 <https://doi.org/10.1086/593688>.
44
45
- 46 46. Pieniak S, Aertsens J, Verbeke W. Subjective and objective knowledge as determinants of organic
47
48 vegetables consumption. *Food Qual Preference* 2010;**21**:581-88.
49
50 <https://doi.org/10.1016/j.foodqual.2010.03.004>.
51
52
- 53 47. Schinckus L, Dangoisse F, Van den Broucke S, *et al.* When knowing is not enough: emotional distress
54
55 and depression reduce the positive effects of health literacy on diabetes self-management. *Patient*
56
57 *Educ Couns* 2018;**101**:324-30. doi: 10.1016/j.pec.2017.08.006.
58
59
60

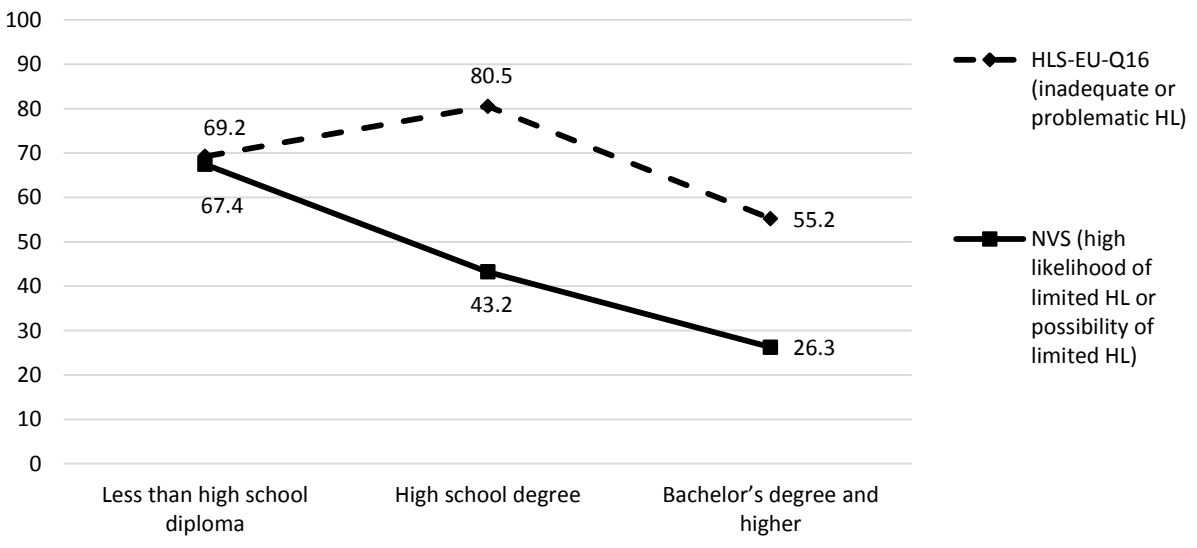
- 1
2
3 48. Stolp S, Zabucky KM. Contributions of metacognitive and self-regulated learning theories to
4 investigations of calibration of comprehension. *International Electronic Journal of Elementary*
5 *Education* 2017;**2**:7-31.
6
7
8
9
10 49. Belmi P, Neale MA, Reiff D. *et al.* The social advantage of miscalibrated individuals: the relationship
11 between social class and overconfidence and its implications for class-based inequality. *J Pers Soc*
12 *Psychol* (2019). doi: 10.1037/pspi0000187
13
14
15
16 50. Crondahl K, Karlsson LE. The nexus between health literacy and empowerment: a scoping review.
17 *Sage Open* 2016;**6**:1-7. <https://doi.org/10.1177/2158244016646410>
18
19
20
21 51. Nutbeam D. Health literacy as a public health goal: a challenge for contemporary health education
22 and communication strategies into the 21st century. *Health Prom Intern* 2000;**15**:259-67.
23 <https://doi.org/10.1093/heapro/15.3.259>.
24
25
26
27 52. Chinn D. Critical health literacy: a review and critical analysis. *Soc Sci Med* 2011;**73**:60-7. doi:
28 10.1016/j.socscimed.2011.04.004.
29
30
31
32 53. Van der Heide I, Heijmans M, Schuit AJ, *et al.* Functional, interactive and critical health literacy:
33 varying relationships with control over care and number of GP visits. *Patient Educ Couns*
34 2015;**98**:998-1004. doi: 10.1016/j.pec.2015.04.006.
35
36
37
38 54. Fletcher RH, Fletcher SH, Fletcher Grant S. *Clinical epidemiology: the essentials*, fifth ed., Lippincott
39 Williams & Wilkins, Philadelphia 2012.
40
41
42
43 55. United States Government, Office of Disease Prevention and Health Promotion, Office of the
44 Assistant Secretary for Health, Office of the Secretary, Department of Health and Human Services.
45 Solicitation for Written Comments on an Updated Health Literacy Definition for Healthy People 2030.
46 Available at: [https://www.federalregister.gov/documents/2019/06/04/2019-11571/solicitation-for-](https://www.federalregister.gov/documents/2019/06/04/2019-11571/solicitation-for-written-comments-on-an-updated-health-literacy-definition-for-healthy-people-2030)
47 [written-comments-on-an-updated-health-literacy-definition-for-healthy-people-2030](https://www.federalregister.gov/documents/2019/06/04/2019-11571/solicitation-for-written-comments-on-an-updated-health-literacy-definition-for-healthy-people-2030).
48
49
50
51
52
53
54
55
56
57
58
59
60

A



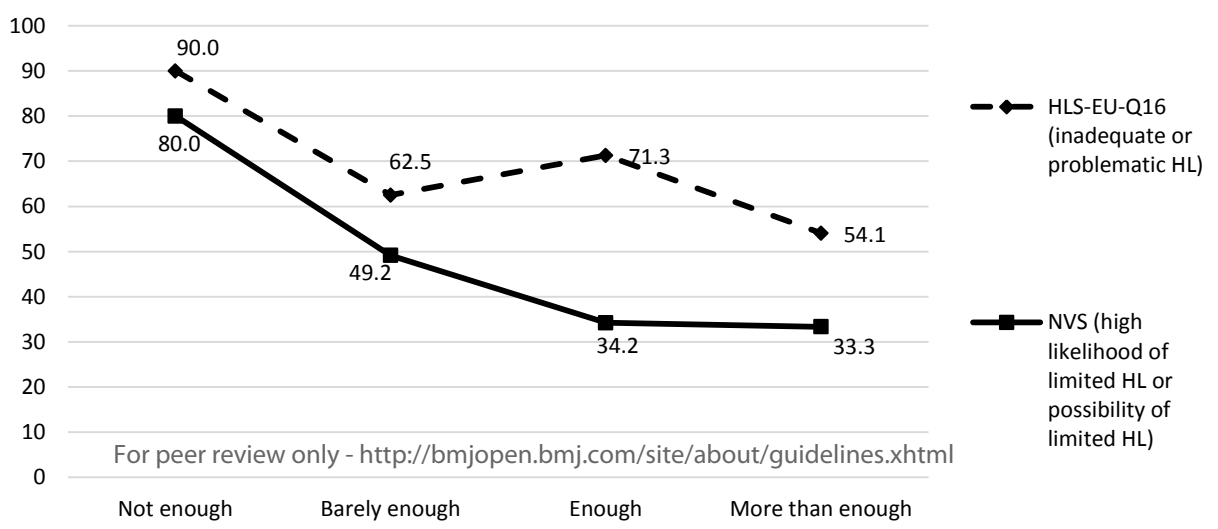
Low Health Literacy by educational level (%)

B



Low Health Literacy by Financial resources (%)

C



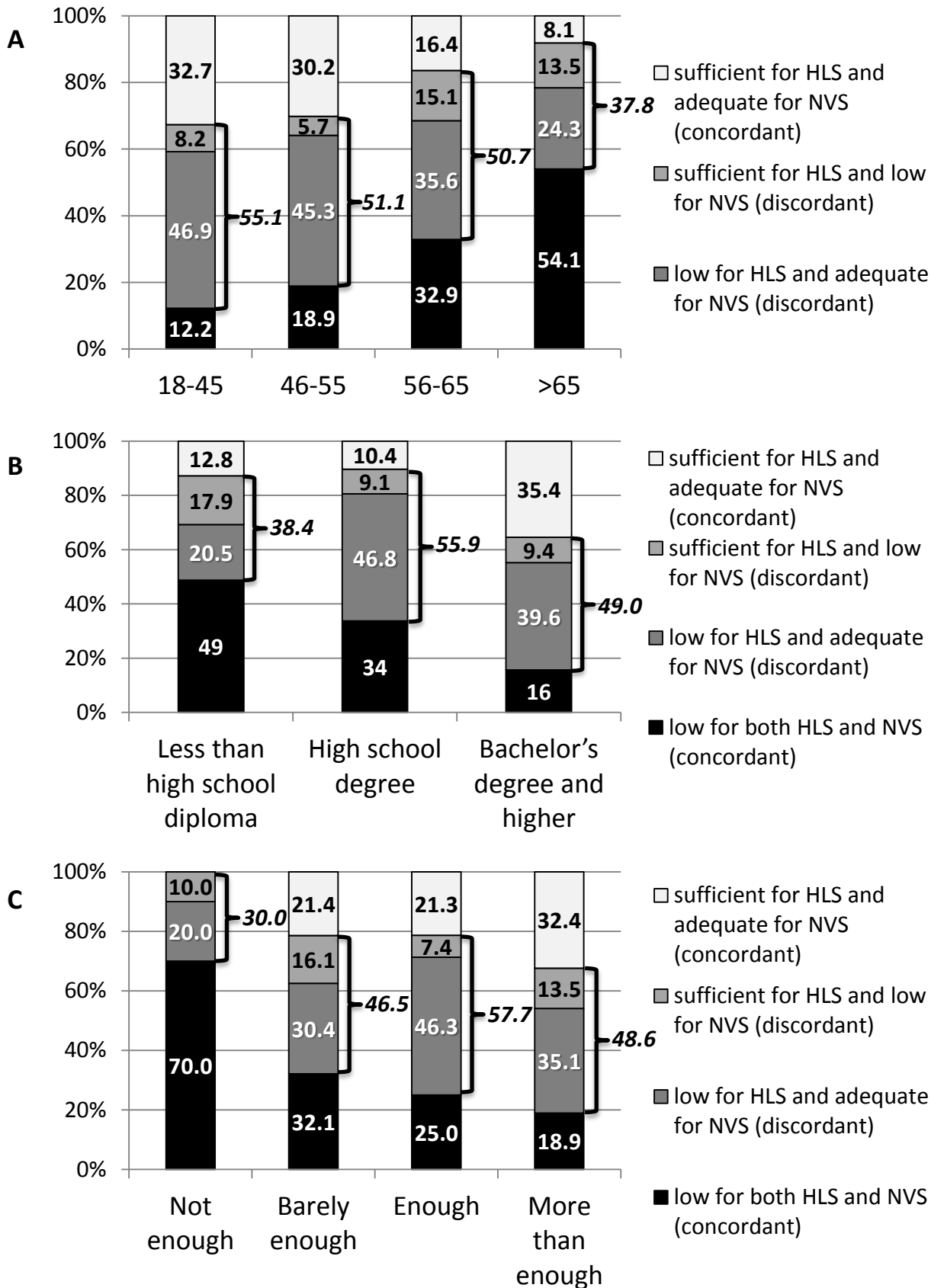


Table S1. Percentage of people with regards to the two health literacy measures (HLS-EU-Q16 and NVS) by age class, educational level, and financial resources.

CI= Confidence Interval.

Variables		HL level			
		Raw percentage (95% CI)			
		low for both HLS and NVS (concordant)	low for HLS and adequate for NVS (discordant)	sufficient for HLS and low for NVS (discordant)	sufficient for HLS and adequate for NVS (concordant)
Age	≤45	12.2% (4.6–24.8%)	46.9% (32.5–61.7%)	8.2% (2.3–19.6%)	32.7% (19.0–47.5%)
	46–55	18.9% (9.4–32%)	45.3% (31.6–59.6%)	5.7% (1.2–15.7%)	30.2% (18.3–44.3%)
	56–65	32.9% (22.3–44.9%)	35.6% (24.7–47.7%)	15.1% (7.8–25.4%)	16.4% (8.8–27.0%)
	>65	54.1% (36.9–70.5%)	24.3% (11.8–41.2%)	13.5% (4.5–28.8%)	8.1% (1.7–21.9%)
Educational level	Less than high school diploma	48.7% (32.4–65.2%)	20.5% (9.3–36.5%)	17.9% (7.5–33.5%)	12.8% (4.3–27.4%)
	High school degree	33.8% (23.4–45.4%)	46.8% (35.3–58.5%)	9.1% (3.7–17.8%)	10.4% (4.6–19.4%)
	Bachelor’s degree and higher	15.6% (9–24.5%)	39.6% (29.7–50.1%)	9.4% (4.4–17.1%)	35.4% (25.9–45.8%)
Financial resources at disposal from own or family income enough to get to the end of the month	Not enough	70.0% (34.8–93.3%)	20.0% (2.5–55.6%)	10.0% (0.3–44.5%)	0% (0–30.8%)
	Barely enough	32.1% (20.3–40%)	30.4% (18.8–44.1%)	16.1% (7.6–28.3)	21.4% (11.6–34.4%)
	Enough	25.0% (17.2–34.3%)	46.3% (36.7–56.2%)	7.4% (3.3–14.1%)	21.3% (14–30.2%)
	More than enough	18.9% (8–35.2%)	35.1% (20.2–52.5%)	13.5% (4.5–28.8%)	32.4% (18–49.8%)

STROBE 2007 (v4) Statement—Checklist of items that should be included in reports of cross-sectional studies

Section/Topic	Item #	Recommendation	Reported on page #
Title and abstract	1	(a) Indicate the study's design with a commonly used term in the title or the abstract	1
		(b) Provide in the abstract an informative and balanced summary of what was done and what was found	2
Introduction			
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported	4; 5
Objectives	3	State specific objectives, including any prespecified hypotheses	5; 6
Methods			
Study design	4	Present key elements of study design early in the paper	6
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection	6
Participants	6	(a) Give the eligibility criteria, and the sources and methods of selection of participants	7
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable	6; 7; 8
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group	6; 7; 8
Bias	9	Describe any efforts to address potential sources of bias	8
Study size	10	Explain how the study size was arrived at	5; 6
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why	8; 9
Statistical methods	12	(a) Describe all statistical methods, including those used to control for confounding	8; 9
		(b) Describe any methods used to examine subgroups and interactions	8; 9
		(c) Explain how missing data were addressed	8; 9
		(d) If applicable, describe analytical methods taking account of sampling strategy	N/A
		(e) Describe any sensitivity analyses	N/A
Results			

Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed	11
		(b) Give reasons for non-participation at each stage	11
		(c) Consider use of a flow diagram	N/A
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders	11, 12
		(b) Indicate number of participants with missing data for each variable of interest	19
Outcome data	15*	Report numbers of outcome events or summary measures	11; 12; 13
Main results	16	(a) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included	21-23
		(b) Report category boundaries when continuous variables were categorized	19-22
		(c) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period	N/A
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses	N/A
Discussion			
Key results	18	Summarise key results with reference to study objectives	13
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias	16
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence	13-15
Generalisability	21	Discuss the generalisability (external validity) of the study results	15
Other information			
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based	17

*Give information separately for cases and controls in case-control studies and, if applicable, for exposed and unexposed groups in cohort and cross-sectional studies.

Note: An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at <http://www.plosmedicine.org/>, Annals of Internal Medicine at <http://www.annals.org/>, and Epidemiology at <http://www.epidem.com/>). Information on the STROBE Initiative is available at www.strobe-statement.org.