Barriers to Organizational Health Literacy at Public Health Departments in Germany

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ABSTRACT

Background: Strengthening individual health literacy and knowledge about health challenges are important preventive approaches in public health to improve health equality. Health care organizations have come into focus in this regard. They need to raise their organizational health literacy (OHL) to help users to access and navigate information and services. **Objective:** In Germany, public health departments (PHDs) are responsible for public and environmental health at the population level. This study breaks new ground as it is the first to investigate the OHL of these health care organizations. The study attempts to answer what barriers keep them from raising their OHL and how can these be overcome? **Methods:** In this explorative study, 10 guideline-oriented interviews with experts from PHDs were conducted in two states in Germany. Qualitative content analysis was used to extract the results from the experts´ statements. **Key Results:** Eleven barriers to raising OHL were identified. Obstacles were found in leadership and organizational culture, design and implementation of information, and in human resources. False expectations due to negative preconceptions about public service were identified as a new barrier that had not been elucidated in prior literature. The same applies to lack of cooperation on cross-sectoral topics as well as lack of accessibility. Clear communication of tasks and clear jurisdictional authority are some of the recommendations for lowering these barriers. Other examples include identifying and using synergies and involvement of target groups. **Conclusions:** Overcoming these obstacles could improve the OHL of German PHDs. This, in turn, could improve the health of the general population and thus contribute significantly to overall public health. Extrapolating to the whole of Germany and other countries could further strengthen research on OHL. **[*HLRP: Health Literacy Research and Practice.* 2021;5(3):e264-e271.]**

Plain Language Summary: Public health departments (PHDs) must be able to help their users access, understand, and use health information and services. This competence is called organizational health literacy (OHL). Ten experts from German PHDs were interviewed about barriers to raising OHL. This article reports the barriers identified and recommendations for lowering them, as well as three previously unknown obstacles.

Public health service (Öffentlicher Gesundheitsdienst) is the third pillar of the German health care system, together with inpatient and outpatient (ambulant) care provided by hospitals and local physicians, respectively. It consists of health authorities at the national, federal state, and municipal levels. In Germany, there is no national public health agency comparable to the National Health Service in the United Kingdom or other countries. Instead, approximately 400 local public health departments (PHDs, Gesundheitsämter) in urban and rural district administrations are at the heart of the public health service (Plümer, 2018). They vary in size, structure, and tasks, because in Germany it is the federal states that are responsible for health policy (Busse & Blümel, 2014). However, all of them share a number of responsibilities, such as monitoring, protecting, and promoting the health of the population as well as identifying and tackling public health hazards (Plümer, 2018). These local PHDs provide information and a great number of services for the public in the area they serve.

To make healthy decisions, citizens need to be able to access, understand, assess, and apply the information and services provided. This ability is called health literacy (HL)

(Sørensen et al., 2012). The World Health Organization's (WHO, 2016) Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development recognizes HL as a critical health determinant. HL empowers and drives equality to reach the goal of a healthy environment and life for all (WHO, 2016). Moreover, the United Nations (2020) considers HL important for achieving targets related to sustainable development goals. In Germany, the foundation of the national Alliance for Health Literacy (Bundesministerium für Gesundheit, 2017) in 2017 was followed by the development of the National Action Plan on Health Literacy in 2018 (Schaeffer et al., 2018).

All of these entities acknowledge that, in addition to improving individual HL, the systems in which people move have to change as well (Rudd, 2015). Health care organizations need to make an effort to raise their organizational health literacy (OHL). No all-encompassing definition for OHL has been agreed upon (Meggetto et al., 2018). For this study, OHL is understood as "the degree to which an organization implements policies, practices, and systems" (Brega et al., 2019, p. 128) that help its users "to navigate, understand, and use information and services to take care of their health" (Brach et al., 2012, p. 1). For organizations to enhance their OHL, it is necessary to understand the relevant attributes and their current OHL level. In any given setting, the measurement of this level depends on the development of a setting-specific OHL concept.

The first conceptual model for health-literate health care organizations was developed by the U.S. Institute of Medicine (Brach et al., 2012). It encompasses 10 attributes and has since become the foundation for a growing number of adaptations worldwide. The model´s attributes should be chosen, implemented, and customized depending on the respective organization´s priorities, and targeted at institutions like hospitals, primary care practices, pharmacies, or nursing homes (Brach et al., 2012). The U.S. Centers for Disease Control and Prevention (CDC) has adapted these to a list of 10 attributes for health departments and similar organizations (CDC, 2020). In addition, the Nebraska Association of Local Health Directors has developed a toolkit for local health departments to assess their HL readiness (Horowitz Center for Health Literacy, University of Maryland School of Public Health 2021).

In 2015, Pelikan and Dietscher presented the Vienna concept of health-literate hospitals and health care organizations (V-HLO) based on the 10 attributes. It encompasses 9 standards, 22 sub-standards, and 160 indicators, as well as a toolbox containing best-practice actions (Pelikan, 2017; Pelikan & Dietscher, 2015). The V-HLO is also available as a self-measurement tool for hospitals (Dietscher & Pelikan, 2017).

A third theoretical model was developed by the New Zealand Ministry of Health, which adapted the 10 U.S. attributes to New Zealand´ health care system and identified 6 OHL dimensions (Ministry of Health, 2015). In 2017, Trezona et al. developed a conceptual framework describing the characteristics of health literacy responsive organizations. This was field-tested and refined as a self-assessment tool in 2020, and it contains 6 dimensions, 22 sub-dimensions, and 110 performance indicators (Trezona et al., 2020).

Next to these setting-specific theoretical models and attributes, barriers, and facilitators to raising OHL are other important factors. A review published in 2018 summarizes barriers for OHL that had been described in the literature reporting on the use of HL guides, mostly for hospitals and other primary care organizations in the United States, Canada, and Australia (Farmanova et al., 2018).

Local PHDs in Germany, like similar organizations in other countries, are the interface between sustainable development goals and specific local actions to promote environmental and public health. Although there is growing attention to individual HL (Bundesministerium für Gesundheit, 2017; Rowlands et al., 2019; Sørensen et al., 2012; United Nations, 2020; WHO, 2016), the concept of OHL has not become disseminated yet at the communal level. Research has

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focused on hospitals and primary care (Bitzer & Spörhase, 2015; Brach et al., 2012; Dietscher & Pelikan, 2017) as well as other settings, such as extra-curricular youth work settings (Wieczorek et al., 2017). To our knowledge, this is the first time that research has been done on the OHL of PHDs in Germany. As PHDs differ from hospitals and other primary care organizations in their structure and tasks, it is expected that barriers to OHL will also differ. This study investigates OHL barriers and facilitators to German PHDs. The first recommendations to overcome these obstacles are also derived from this study.

Other countries can benefit from the results of this explorative study if the insights gained from two federal states can be extrapolated to the whole of Germany and to public health organizations worldwide.

METHODS

Because no studies had been done in this area before, an explorative, qualitative approach was chosen. The design consisted of guideline-oriented, semi-structured interviews with experts from PHDs at the communal level ($n = 8$) up to federal state level ($n = 2$) in two federal states in Germany (Bogner et al., 2009). All PHD staff were treated as experts because they have process-related and interpretative-evaluative knowledge about their respective organizations. The recruiting of interview partners started with a list of key people drawn up after informal talks. The first state (Saxony, in eastern Germany) was chosen as a starting point for logistical reasons. The second state (North Rhine-Westphalia, in western Germany) was chosen as a contrast to the first to strengthen reliability of the results. The main differences were the two states' statutory emphasis on networks and health conferences as well as their historical and geographical differences. Using a snowball sampling technique, each interview partner was asked for further recommendations. Organizations and experts were selected from the resulting list for a wide range and even distribution of general characteristics, including gender, age, urban/rural district administrations, organizational size, and administrative levels. This way, the yield of the study was as broad and as extensive as possible given the limitations of an explorative study with a small number of interviews. The sample size was deemed adequate because thematic saturation was aimed at and reached for the two states.

Eligible experts were invited by email to participate, followed by a phone call to schedule an interview. All interview partners gave informed consent. The study design was approved by the ethics committee of Bielefeld University. The interviewer (A.M.) was an employee at a communal PHD herself at the time of the interviews, which was both a limitation and a benefit. Advantages included field access as well as knowledge about the inner workings of PHDs.

A semi-structured interview guide in German was developed by operationalizing known OHL concepts (Brach et al., 2012; CDC, 2020; Ministry of Health, 2015; Pelikan & Dietscher, 2015) and barriers for OHL (Farmanova et al., 2018). It was pilot tested by the study's lead author (A.M.) The interview started with the experts' personal background and asking for their understanding of HL. To ensure the same level of understanding for all interviewees, the definition of HL was given by the interviewer before the second part of the interview. The interviewer then asked about the experts' experiences with HL and related measures at their organization. A third series of questions focused on difficulties, barriers, and facilitators regarding development and implementation of information and services.

All audio records were transcribed verbatim by the study author using f4transkript. Transcripts were then imported into MAXQDA 2020 (release 20.0.6) to allow for comprehensive content analysis. Qualitative content analysis was done by the author. To strengthen results further, two of the interviews were also analyzed by one of the co-authors (V. L.).

Open coding of data was used, with subsequent sorting of codes into broader categories. In a second run, main categories were developed deductively from the underlying theories. They were then tested, revised, and supplemented with subcategories developed inductively from the text. Relationships between categories were developed in an iterative process. Results from both approaches were matched and merged. Final results were compared to known OHL barriers.

RESULTS

Ten in-person interviews were conducted and recorded by the study author between October 2018 and January 2020. Those interviews yielded 10.2 hours of recorded audio. An even distribution of general characteristics was achieved for some but not all factors (**Table 1**). As expected, the scope of the experts´ views on processes in their organizations widened with increased hierarchy levels. The small number of experts from the federal state level ($n = 2$) were chosen for an additional top-down view of local PHDs.

Main Barriers

Qualitative content analysis revealed 11 OHL barriers (**Table 2**) at PHDs in two German states. Three main areas of barriers were reported by the interview partners, which agrees with the review on OHL barriers by Farmanova et al. (2018). **Table 2** shows the barriers found in this study.

TABLE 1

General Characteristics of Experts and Their Respective Regions

Interview Number	Age, years	Gender	Position	Academic Degree/Training	Size of Organization (population served)	Region of PHD	Federal State
1	51	Female	Clerk	Bachelor of Engineering (analog)	227,800	Communal/rural	1
2	47	Female	Team leader	MD, MPH	4,078,000	Federal state	1
3	37	Female	Clerk, acting team leader	PhD (biology)	245,600	Communal/rural	1
4	37	Female	Clerk	MD	4,078,000	Federal state	1
5	44	Female	Team leader	PhD (philosophy)	554,600	City	1
6	34	Female	Team leader	Bachelor of Administration (analog)	254,900	Communal/rural	1
7	48	Female	Team leader	MD	302,000	Communal/rural	2
8	57	Female	Head of department	MD	360,000	Communal/rural	2
9	51	Male	Clerk	Master of Sociology	333,800	City	2
10	63	Male	Head of department	MD	333,800	City	2

Note. MD = Doctor of Medicine; MPH = Master of Public Health; PhD = Doctor of Philosophy; PHD = public health department.

Leadership and organizational culture. Barriers 1 to 3 describe how leadership and organizational culture can promote or hinder OHL. Most experts reported a low priority of HL and related activities (barrier 1). "*It´s a fact that public health departments have many tasks, and, unfortunately, this* [OHL, author´s note] *is not a top priority*" (interview [i] 3, section [s] 24; all translations by the study author). Lack of commitment to HL, also criticized by 9 of 10 interviewees, is mostly due to (a lack of) legal requirements and political pressures (barrier 2). "*What kind of legal mandate do we have? What are we allowed to do as a public health department? (…) what is our jurisdiction? What is the environmental department´s jurisdiction? That is the only way we can operate. We can only implement what we are tasked with from above*" (i1, s13). Without the buy-in and support from the organizations´ leadership, change is slow and nearly impossible (barrier 3). The same nine interview partners reported this problem. "*I couldn´t imagine this* [making OHL a priority, author´s note] *now (…) especially since I don't think there is any interest from the head of the department, none*" (i1, s81).

Design and implementation of information and improvement interventions. Barriers 4 to 8 relate to the design of improvement interventions. One-half of the experts interviewed admitted to a lack of culture of change and innovation at their organization (barrier 4), hampering efforts to implement changes toward higher OHL. "*Basically, they are happy when everything is running and (…) why should you change something there?*" (i1, s17). The importance of trailblazers in the form of a single person or group of interested parties in an organization (barrier 5) was pointed out by all experts. Some saw themselves in that position and reported the difficulties they had. "*Even if I went one step too far during my professional years (...). When I approached people outside of my competence, it came back to haunt me. So what do you do afterwards? You withdraw and do only what you are told so nobody can use it against you*" (i1, s81). The experts agreed that anyone championing change is hampered by strict hierarchies, lack of autonomy, and reprisals for overstepping their bounds.

Procedures, policies, or tools supporting health-literate practice were only known to two of the interviewees. The others acknowledged this lack of knowledge (barrier 6) and even wished it was different. "*I think it is important to set standards for certain actions, even consultations or activities*" (i6, s85).

Not having enough time was almost always mentioned in connection with not having enough funds, specialists, or equipment. This lack of resources was another barrier (barrier 7) mentioned by all of the interview partners. "*So with more staff time (…) you can do a whole lot more (...)*" (i4, s21).

TABLE 2

Key Barriers to Organizational Health Literacy for Public Health Departments in Two Federal States in Germany

Barrier Number	Key Barrier
1	Low priority of health literacy and related activities
2	Lack of commitment to health literacy due to legal requirements and political pressures
3	Limited or no buy-in from leadership
4	Lack of culture of change and innovation
5	No "change champions" in the organization; existing change champions are hindered by strict hierarchies, lack of autonomy, as well as reprisals for overstepping their bounds
6	Not having procedures, policies, or protocols supporting health-literate practice
7	Not having enough time; lack of resources
8	Lack of accessibility and navigability of the organization itself as well as its services due to lack of involving target groups in development and implementation; lack of digitalization
9	Lack of employees´ individual health literacy, in part due to lack of training in health literacy
10	False expectations, prejudices, and negative preconceptions about public service authorities among the citizens
11	Lack of cooperation on cross-sectoral topics, lack of networking as well as lack of engagement in current research

Another factor mentioned by the experts was the lack of accessibility and navigability of the organization itself and its services (barrier 8). "*We just have these signs and this guidance system, which with these big buildings can be confusing even to us*" (i6, s53). Most experts complained about the lack of proximity to the citizens, and some thought this was in part due to a failure to involve target groups in development and implementation (barrier 8). "*(…) that would be (…) one approach to simply ask someone concerned whether what you have developed does the job or not*" (i3, s58). Another cause named was the failure to use the possibilities opened up by digitalization (barrier 8). "*(…) what I would VERY much like to change would be a good website where good information is right there [and you don't have to look*

for it] because nowadays a lot is done and happens on the internet" (i3, s88).

Human resources. Barrier 9 (**Table 2**) refers to human resources, as the skills and attitudes of the workforce will have a significant influence on OHL. Nine of 10 experts saw a lack of the employees´ personal HL as an important barrier. Eight experts attributed this to insufficient training in HL and other health-related topics. "*(…) regarding some subjects, the people who want to be advised by us (…) sometimes know more than we do because we are often denied much for cost reasons and the like; because we simply cannot acquire the skills, because the training courses cost a lot of money (…)*" (i3, s88).

All of the experts saw false expectations, stemming from prejudices and negative preconceptions about public service among the citizens, as a major problem (barrier 10). The resulting conflicts with disappointed or aggressive patients can be a problem. "*(…) emotions well up very quickly, and clearly, an office like this does not always meet the citizens´ expectations. It follows that there are situations where you are exposed to aggression*" (i3, s44).

Another barrier all the interview partners agreed on was a lack of cooperation on cross-sectoral topics manifesting itself as a failure to network and engage in current research (barrier 11). This was especially true for all of the environmental health topics the experts mentioned. "*So I still think that these things* [health and environment, author´s note] *all belong together, that everything has to be put down on the table, and it´s only then that you can see the whole picture*" (i1, s13).

PRELIMINARY RECOMMENDATIONS

Organizational changes can start at any one of the barriers. Initial changes will lower some barriers and use facilitators, leading to further changes in other areas. **Table 3** shows some preliminary strategies and starting points expressed by the experts.

As soon as leadership makes OHL a priority, funds and efforts can be channeled there. "*That you (…) give the whole thing* [HL, author´s note] *a bit more weight on the agenda, to give it a little bit more importance*" (i3, s114). The leadership´s commitment to making HL integral to its mission, structure, and operations is, therefore, an important step in raising OHL.

Several steps can be taken to improve design and implement information and improvement measures; therefore, leadership should promote a culture of change and innovation as a base for active improvement as well as support employees willing to implement change: "*I could certainly commit myself more to it* [implementing an improvement measure, author´s note] *and say that I would definitely want*

TABLE 3

Preliminary Recommended Actions to Overcome Barriers for Organizational Health Literacy

Main Barrier Group	Recommended Action
Leadership and organizational culture	Make organizational health literacy a priority
	Leadership commits to making health literacy integral to its mission, structure, and operations
Design and implementation of information and improvement interventions	Promote a culture of change and innovation
	Hire and support agents of change
	Implement quality assurance systems and participate in internal and external audits
	Disseminate and use health literacy tools and guidelines
	Provide enough staff as well as financial and other resources
	Provide easy access to health information and services and navigation assistance, including online
	Promote clear and citizen-oriented communication
	Involve target groups in development
Human resources	Prepare the workforce to be health literate
	Create training opportunities focused on health literacy
False expectations, prejudices, and negative preconceptions about public service authorities among the citizens	Clear communication of tasks and jurisdiction (e.g., using social media and other media)
Lack of cooperation on cross-sectoral topics, lack of networking, as well as lack of engagement in current research	Identify and use synergies
	Encourage and strengthen internal and external cooperation by networking, communicating, and involving each other on environmental health-relevant topics like climate change
	Take part in and use results of current research

to do this. I think leadership would then support me and have me take care of it personally" (i1, s25). By implementing quality assurance systems, PHDs can constantly improve their work: "*We have internal audits (…), and an external audit once a year. We are a TÜV-certified* [TÜV: German Association for Technical Inspection, author´s note] *district administration*" (i7, s55). Existing HL tools and guidelines should be disseminated and used more widely. Another important factor is the provision of enough staff as well as financial and other resources: "*Yes, resources are the most important thing. And that can only be done through of cooperation or just by giving more money to the departments*" (i9, s146). PHDs should provide easy access and navigation assistance to health information and services. This includes online services. To promote clear and citizen-oriented communication, they should also involve target groups in development and implementation: "*(…) for this* ["Movement in the district" leaflet, author´s note] *(…) I just wanted to have the perspective of the elderly*" (i5, s49).

Because human resources staff the organization, teaching the workforce to be health-literate can be considered one of the most important steps. By creating HL-focused training opportunities, the HL of individual employees can be raised: "*It is important that employees are health-literate. They usually are, due to their professional training, but that in your everyday work you learn not to overextend yourself*" (i9, s108).

To fight false expectations and negative preconceptions about public service authorities, the experts suggested clear communication of tasks and jurisdiction: "*People simply are not aware of what our work really encompasses, what services we offer and (…) I would like to communicate that more*" (i6, s83). Using social media to explain the range of services better was another recommendation.

The lack of networking and cooperation could be tackled by encouraging communication about and mutual involvement in environmental health-relevant topics like climate change. By identifying and using synergies, scarce resources could be used to mutual benefit. One example given by an expert was the use of joint software or databases: "*I would like to be able to use a shared online map that several departments can access*" (i1, s69). Taking part in and using results of current research was another important recommendation given by the interview partners.

DISCUSSION

Most of the barriers reported by the interview partners were known from previous studies. Eight of them were confirmed entirely, or with only slight additions (barriers 1-7, 9), whereas four barriers reported by Farmanova et al. (2018) could not be confirmed for German PHDs. The "complexity of HL tools and guidelines" was not a barrier according to the experts, and they did not detect "a failure to perceive it as advantageous to become health-literate" as an obstacle. "Role ambiguity among staff" was also not identified as a barrier. A certain "lack of awareness of HL" could be construed from the experts´ lack of knowledge about HL tools; however, all of the experts demonstrated knowledge about the underlying concept of HL. This barrier could, therefore, not be corroborated either (Farmanova et al., 2018).

Three barriers (8, 10, 11) were identified for the first time in the context of PHDs. All three go back to our original assumptions that PHDs are different from other organizations. False expectations and negative preconceptions about public service authorities (barrier 10) could stem from a lack of knowledge about what PHDs do. Although almost every citizen in Germany has regular contact with primary care doctors, private practice physicians, and even hospitals, many people do not have any regular contact with their local PHD. This new barrier could show cultural differences between the countries represented in the review by Farmanova et al. (2018) and Germany, so more research is needed. Together with the lack of accessibility and navigability (barrier 8), the lack of cooperation on cross-sectoral topics and engagement in current research (barrier 11) is particularly troubling. Both barriers directly contradict the self-imposed mission statement of the German public health service (Länderoffene Projektgruppe, 2018, p. 1).

Differences between federal states were negligible for every factor, and far more variation was found between urban and rural departments. Close proximity to and cooperation with universities and being part of formalized networks like the WHO European Healthy Cities Network (WHO, 2018) were cited as facilitators in cities, compared to being reported as missing in towns and rural areas. Current environmental health challenges could offer a chance to cooperate with local environmental departments to build new networks.

Regarding the involvement of target groups, a pilot of the V-HLO in Austria found that this is actually one of the weakest points of implementing OHL in Austria (Dietscher & Pelikan, 2017). In this study, most of the experts voiced doubts about the practicality and usefulness of involving citizens in the development of information or services. This goes back to the lack of resources and the negative experiences with false expectations. A more concerted effort could help allocate scarce resources more effectively, allowing for more time and staff. This leads to the question of how synergies between PHDs and environmental authorities can be harnessed, something which also warrants further research.

The association made between lacking commitment to HL and lacking legal requirements shows that efforts need to be increased to enhance OHL via policies at a federal or national level. This demand has been brought up by the National Action Plan on HL and a subsequent strategy article (Schaeffer et al., 2018; Schmidt-Kaehler et al., 2019). Available activities and documents from the National Action Plan and other initiatives could function as an orientation for PHDs. Awareness of available tools must be raised. Further research is needed on compiling measures recommended by the experts and combining them with measures in existing tools and guides (CDC, 2020; Horowitz Center for Health Literacy, University of Maryland, School of Public Health 2021; Ministry of Health, 2015; Schaeffer et al., 2018).

STUDY LIMITATIONS

Several limitations must be taken into account, including geographical and linguistic (interviews in German only). The interviewer´s role as co-expert might have caused interview partners to hold back some information or negative experiences, thinking that it might be known already, or else out of fear of looking uninformed.

Time restrictions in getting access to some experts as well as bias toward interview partners eager to take part in scientific research have to be taken into account. The main effect expected on results is a possible over-reporting of successful projects and facilitators instead of barriers.

The explorative character and small sample size of this study limits extrapolation. Further tests and validation with more organizations and federal states would be desirable. Implementation studies on the recommendations for overcoming barriers to OHL and their effect on individual HL are necessary.

CONCLUSIONS

To improve OHL effectively, specific barriers unique to each type of organization must be defined and targeted. For PHDs in Germany, 11 such barriers were identified. Three of them had not been identified before. Expert interviews with employees at PHDs yielded preliminary recommendations for overcoming these obstacles. Based on their responsibility for public health and the number of people served by PHDs, improving their OHL is of great importance. This study can support the selection of adequate ways of doing so.

REFERENCES

Bitzer, E. M., & Spörhase, U. (2015). Gesundheitskompetenz in der medizinische Rehabilitation und die Bedeutung für die Patientenschulung [Health Literacy and patient education in medical rehabilitation]. *Bundesgesundheitsblatt, Gesundheitsforschung, Gesundheitsschutz, 58*(9), 983-988. https://doi.org/10.1007/s00103-015-2205-7 PMID:26153473

Brach, C., Keller, D., Hernandez, L. M., Baur, C., Parker, R., Dreyer, B., Schyve, P., Lemerise, A. J., & Schillinger, D. (2012). *Ten attributes of health literate health care organizations*. National Academy of Medicine. https://doi.org/10.31478/201206a

Brega, A. G., Hamer, M. K., Albright, K., Brach, C., Saliba, D., Abbey, D., & Gritz, R. M. (2019). Organizational health literacy: Quality improvement measures with expert consensus. *HLRP: Health Literacy Research and Practice, 3*(2), e127-e146. https://doi.org/10.3928/24748307-20190503-01 PMID:31294314

Bogner, A., Littig, B., & Menz, W. (Eds.). (2009). *Interviewing experts. Methodology and practice*. Palgrave Macmillan. https://doi.org/10.1057/9780230244276

Bundesministerium für Gesundheit. (2017). *Gemeinsame Erklärung des Bundesministeriums für Gesundheit, der Spitzenorganisationen im Gesundheitswesen und des Vorsitzlandes der Gesundheitsministerkonferenz der Länder zur Bildung einer Allianz für Gesundheitskompetenz. [Joint declaration by the Federal Ministry of Health, the umbrella organisations in the health sector and the country chairing the Conference of Health Ministers of the federal states on the formation of an Alliance for Health Literacy.]* https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/3_Downloads/E/Erklaerungen/Allianz_fuer_Gesundheitskompetenz_Abschlusserklaerung.pdf

Busse, R., & Blümel, M. (2014). Germany: Health system review. *Health Systems in Transition, 16*(2), 1-296, xxi. PMID:25115137

Centers for Disease Control and Prevention. (2020). *Be an organization that advances health literacy*. https://www.cdc.gov/healthliteracy/planact/steps/index.html

Dietscher, C., & Pelikan, J. M. (2017). Health literate hospitals and healthcare organizations – results from an Austrian feasibility study on the self-assessment of organizational health literacy in hospitals. In D. Schaeffer & J. M. Pelikan. (Eds.), *Health literacy: Forschungsstand und perspektiven* (pp. 303-313). Hogrefe.

Farmanova, E., Bonneville, L., & Bouchard, L. (2018). Organizational health literacy: Review of theories, frameworks, guides, and implementation issues. *Inquiry, 55*, 46958018757848. https://doi.org/10.1177/0046958018757848 PMID:29569968

Horowitz Center for Health Literacy, University of Maryland, School of Public Health. (2021). *Health literacy champions*. https://sph.umd.edu/center/hchl/health-literacy-champions

Länderoffene Projektgruppe. (2018). *Leitbild für einen modernen Öffentlichen Gesundheitsdienst. Zustän-digkeiten. Ziele. Zukunft. [Mission statement for a modern public health service. Authorities. Goals. Future.]* https://www.akademie-oegw.de/die-akademie/leitbild-oegd.html

Meggetto, E., Ward, B., & Isaccs, A. (2018). What's in a name? An overview of organisational health literacy terminology. *Australian Health Review, 42*(1), 21-30. https://doi.org/10.1071/AH17077 PMID:29117893

Ministry of Health. (2015). *Health literacy review: A guide*. https://www.health.govt.nz/publication/health-literacy-review-guide

Pelikan, J. M. (2017). Gesundheitskompetente Krankenbehandlungseinrichtungen. [Health Literate Health Care Organizations.] *Public Health Forum 25*(1), 66-70. https://doi.org/10.1515/pubhef-2016-2117

Pelikan, J. M., & Dietscher, C. (2015). Warum sollten und wie können Krankenhäuser ihre organisationale Gesundheitskompetenz verbessern? [Why should and how can hospitals improve their organizational health literacy?]. *Bundesgesundheitsblatt, Gesundheitsforschung, Gesundheitsschutz, 58*, 989-995. https://doi.org/10.1007/s00103-015-2206-6 PMID:26168864

Plümer, K. D. (2018). Germany. In B. Rechel, A. Maresso, A. Sagan, C. Hernández-Quevedo, G. Williams, E. Richardson, E. Jakubowski, & E. Nolte (Eds.). *Organization and financing of public health services in Europe – Country reports* (pp. 35–47). World Health Organization. https://www.euro.who.int/__data/assets/pdf_file/0011/370946/public-health-services.pdf

Rowlands, G., Trezona, A., Russell, S., Lopatina, M., Pelikan, J., Paasche-Orlow, M., Drapkina, O., Kontsevaya, A., Sørensen, K. (2019). What is the evidence on the methods, frameworks and indicators used to evaluate health literacy policies, programmes and interventions at the regional, national and organizational levels? In: *WHO Regional Office for Europe, Health Evidence Network Synthesis Report No. 65*. https://www.euro.who.int/en/publications/abstracts/what-is-the-evidence-on-the-methods,-frameworks-and-indicators-used-to-evaluate-health-literacy-policies,-programmes-and-interventions-at-the-regional,-national-and-organizational-levels-2019

Rudd, R. E. (2015). The evolving concept of health literacy: New directions for health literacy studies. *Journal of Communication in Healthcare, 8*, 7-9. https://doi.org/10.1179/1753806815Z.000000000105

Schaeffer, D., Hurrelmann, K., Bauer, U., & Kolpatzik, K. (Eds.). (2018). *Nationaler Aktionsplan Gesund-heitskompetenz. Die Gesundheitskompetenz in Deutschland stärken*. KomPart.

Schmidt-Kaehler, S., Schaeffer, D., Hurrelmann, K., & Pelikan, J. (2019). *Strategiepapier #4 zu den Empfeh-lungen des Nationalen Aktionsplans. Gesundheitskompetenz als Standard auf allen Ebenen im Gesundheitssystem verankern. [Strategy paper #4 on the recommendations of the National Action Plan. Anchor health literacy as a standard at all levels in the health system.]* Nationaler Aktionsplan Gesundheitskompetenz. https://doi.org/10.4119/unibi/2935460

Sørensen, K., Van den Broucke, S., Fullam, J., Doyle, G., Pelikan, J., Slonska, Z., Brand, H., & the (HLS-EU) Consortium Health Literacy Project European. (2012). Health literacy and public health: A systematic review and integration of definitions and models. *BMC Public Health, 12*(80), 80. https://doi.org/10.1186/1471-2458-12-80 PMID:22276600

Trezona, A., Dodson, S., Fitzsimon, E., LaMontagne, A.D., Osborne, R.H. (2020). Field-Testing and refinement of the Organisational Health Literacy Responsiveness Self-Assessment (Org-HLR) tool and process. *International Journal of Environmental Research and Public Health, 17*(3), 1000. https://doi.org/10.3390/ijerph17031000 PMID:32033385

Trezona, A., Dodson, S., Osborne, R.H. (2017). Development of the Organisational Health Literacy Responsiveness (Org-HLR) framework in collaboration with health and social services professionals. *BMC Health Services Research, 17*(1), 513. https://doi.org/10.1186/s12913-017-2465-z PMID:28764699

United Nations. (2020). *The sustainable development agenda*. https://www.un.org/sustainabledevelopment/development-agenda/

Wieczorek, C. C., Ganahl, K., & Dietscher, C. (2017). Improving organizational health literacy in extracurricular youth work settings. *HLRP: Health Literacy Research and Practice, 1*(4), e233-e238. https://doi.org/10.3928/24748307-20171101-01 PMID:31294268

World Health Organization. (2016). *Shanghai declaration on promoting health in the 2030 Agenda for Sustainable Development*. https://www.who.int/healthpromotion/conferences/9gchp/shanghai-declaration.pdf?ua=1

World Health Organization. (2018). *WHO European Healthy Cities Network*. http://www.euro.who.int/en/health-topics/environment-and-health/urban-health/who-european-healthy-cities-network