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PUBLIC HEALTH | RESEARCH ARTICLE

Citizens' experiences with occupational-rehabilitation meetings in Denmark, and measurement of the citizens' health literacy levels: A qualitative study

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Abstract: *Background:* The study explores citizens' subjective experiences with occupational-rehabilitation meetings and their health literacy levels. *Methods:* We used the method "Interpretative Phenomenological Analysis" (IPA) to investigate six citizens' subjective experiences with an occupational-rehabilitation meeting. The nine domain Health Literacy Questionnaire (HLQ) was used to measure the participants' individual levels of health literacy. With an inductive approach, the individual levels of health literacy were compared to the citizens' subjective experiences with the occupational-rehabilitation meeting. *Results:* Six superordinate themes applied to all participants: *the importance of the meeting; the experience of the structure of the meeting; the relationship to the social worker; the importance of an assessor; comprehension of information; and interaction with the occupational-rehabilitation team.* Health literacy levels differed between the participants and a variation was seen within the nine domains. It was found that four of the superordinate themes could be seen in relation to seven of the HLQ domains. *Conclusions:* Within the context of an occupational-rehabilitation meeting, social support, information, and the ability to interact with professionals were important for all participants. These aspects should therefore be considered by the professionals in the

ABOUT THE AUTHORS

The authors are affiliated with the Center for Health Informatics and Innovation, Department of Public Health, University of Copenhagen. The center's particular field of interest is Health Literacy and eHealth Literacy, the main objective being the user's needs and abilities in the context of technology in the health universe, and how we can change the thoughts and behavior of users from being recipients and clients to active consumers of healthcare. The current study contributes to the knowledge about how people on sick-leave perceive the contact with public organizations and how their needs can be addressed. This is one of many important aspects of how the concept of health literacy can be used to understand users in the context of health and care. Author Cecilie Mortensen was at the time of the study affiliated as a student assistant at Departments of Occupational and Social Medicine, University Hospital Holbæk.

PUBLIC INTEREST STATEMENT

In 2013, Denmark introduced occupational-rehabilitation meetings to get citizens on sick leave to return to work earlier.

The occupational-rehabilitation meeting is between the citizen and an occupational-rehabilitation team, which includes relevant professionals from the health sector and the social sector. The meeting can lead to early retirement, a reduced-hour job or an occupational-rehabilitation upgrading progression.

It is important that people on sick-leave can benefit from the meeting to achieve the best outcome.

We here use a qualitative approach and the framework of the Health Literacy Questionnaire to identify themes, which should be addressed in order to achieve a better dialogue and outcome. We found that the professionals should be aware of the participants' needs of social support, information, and the ability to interact with professionals.

occupational-rehabilitation team to enable the citizens to actively take part in the occupational-rehabilitation meeting.

Subjects: Public Health Policy and Practice; Occupational Health and Safety; Medical Social Work; Community Social Work

Keywords: interpretative phenomenological analysis; qualitative research; occupational-rehabilitation meeting; citizens; health literacy; health literacy questionnaire (HLQ)

1. Background

In 2013, Denmark introduced occupational-rehabilitation meetings after the enactment of new legislation regarding an active employment plan (“Beskæftigelsesministeriet - Reform af førtidspension og fleksjob, 2012”). The aim of the occupational-rehabilitation meeting was to get citizens on sick leave to return to work earlier, and to ensure efficient cooperation between the health and social sector. The occupational-rehabilitation meeting is between the citizen and an occupational-rehabilitation team, which includes relevant professionals from the health sector and the social sector. The meeting takes place at and is implemented by the job centre in the municipality. The meeting is dialogue based and intended to ensure that the occupational-rehabilitation plan is made in collaboration between the citizen and occupational-rehabilitation team. The occupational-rehabilitation meeting can lead to early retirement, a reduced-hour job or an occupational-rehabilitation upgrading progression. This way of involving citizens using a team-based approach follows the general movement in healthcare inspired by Wagner’s chronic care model (Wagner, Austin, & Von Korff, 1996). There is a growing tendency towards person-centred care, where the citizen plays an active role in the decision-making regarding their health (Dubbin, Chang, & Shim, 2013; Krupat, Bell, Kravitz, Thom, & Azari, 2001). Involving people in decisions about their health and life conditions offers them greater insight into and ability to manage their situation by themselves, and enables them to make informed decisions. This may increase agency and empower the individual (Schulz & Nakamoto, 2013).

An important prerequisite for making this work is that on the one hand, the citizens are able to acquire, understand and appraise the information provided and able to communicate with the professionals and on the other, that the professionals understand the needs, concerns and abilities of the citizen in order to ensure a truly collaborative effort (Batterham, Hawkins, Collins, Buchbinder, & Osborne, 2016; Shaw, Ibrahim, Reid, Ussher, & Rowlands, 2009).

One approach to inform the professionals about the citizens’ ability to engage with information, make sound judgements, and navigate and actively manage their own health—with the support of the professionals—may be to evaluate the citizens’ health literacy, using, for example, the multi-dimensional health literacy questionnaire (HLQ) (Osborne, Batterham, Elsworth, Hawkins, & Buchbinder, 2013). HLQ conceptualizes health literacy in nine domains (Osborne et al., 2013). The domains range from high to low levels of health literacy. The domains should be understood separately, and are designed to measure and appraise the citizen’s strengths and weaknesses in understanding, finding and applying health information as well as their motivation to use it (Batterham et al., 2014; Kayser, Hansen-Nord, Osborne, Tjønneland, & Hansen, 2015; Osborne et al., 2013).

The aim of this qualitative study is to identify, using “Interpretative Phenomenology Analysis”, the themes that emerge from participants’ experiences and concerns with an occupational-rehabilitation meeting, and to explore whether these themes are reflected in the multi-dimensional understanding of health literacy based on the conceptual model of HLQ. The findings will establish a focus on the domains in HLQ within the context of occupational-rehabilitation meetings in order to help the occupational-rehabilitation team understand citizens’ abilities and needs as reflected in the participants’ self-reported abilities within the nine domains. The aim is to identify the participants’ strengths and weaknesses in playing an active part in the occupational-rehabilitation meetings.

2. Material and methods

2.1. Participants

The initial contact was made to all job centres in Region Zealand’s 17 municipalities in the spring of 2015. Fourteen job centres consented to participate in the study and an agreement about the handling of the invitation letter was made with the health coordinators from the Occupational Health Department in Region Zealand. The citizens who were willing to participate were asked to contact us either by phone or e-mail. Six citizens from four municipalities contacted us and we did not exclude any of these participants. The participants included in the study are defined as citizens who have participated in occupational-rehabilitation meetings and who have been on sick leave due to various illnesses. The social demographics of the participants are shown in Table 1.

Table 1. Demographic characteristics of the participants

	Gender & Age	Marital Status	Outcome of the meeting	Diseases	Education
Participant 1	F, 54	Married	Reduced hour-job	Herniated disc	Medium-cycle higher education
Participant 2	F, 45	Married	Reduced hour-job	Herniated disc, Spinal stenosis and Osteoarthritis	Medium-cycle higher education
Participant 3	M, 60	Widower	Retirement	COPD with 27% lung capacity	Short-cycle higher education
Participant 4	F, 51	Married	Reduced hour-job	Diabetes, heart failure and psoriasis	Short-cycle higher education
Participant 5	F, 60	Married	Unknown	Breast cancer	Short-cycle higher education
Participant 6	F, 54	Married	Reduced hour-job	Throat cancer	Short-cycle higher education

Notes: F–female, M–male.

2.2. Interview

Semi-structured interviews were conducted with the aim to facilitate an interaction that permits the participants to tell about their experiences concerning the occupational-rehabilitation meeting (Smith, 2009). An interview plan was developed, using questions based on the knowledge the authors acquired from fields visits (Brocki & Wearden, 2006; Smith, 2009). The final version of the interview plan comprised overall themes such as: *preparation before the occupational-rehabilitation meeting; motivation; the meeting situation and structure: information, trust and the process after the meeting*. The interviews were all conducted by the first and second authors and lasted 50–90 min. The participants decided where the interview took place; five were conducted in the participant’s home, while one was conducted in a public library. The interviews were recorded with a smartphone and the audio files were stored on a computer. To ensure that the audio files were transcribed in a similar manner, a transcript schedule was developed (Kvale, 1997; Smith, 2009). In order to comply with an ethical responsibility towards the participants, the participants were anonymized (Smith, 2009).

2.3. Research theory and design

This study was theoretically based on the method of “Interpretative Phenomenological Analysis” (IPA). IPA focuses on the detailed analysis of human lived experience. Phenomenology is reflected in IPA when the focus is on understanding people’s attempts to make meaning of their experience. IPA acknowledges that this understanding is arduous for researchers, and IPA is therefore influenced by the hermeneutic version of phenomenology (Brocki & Wearden, 2006; Smith, 2009). IPA entails a double hermeneutic, which means that the researcher tries to make sense of the participants’ attributed meaning of their experiences. Interpretations are based on the researcher’s own conceptions, beliefs and experiences (Rafique & Hunt, 2015; Smith, 2009). IPA has an ideographic sensibility due to its focus on detailed examination of the particular instance of lived experience. As a consequence of this detailed and nuanced analysis, IPA utilizes small samples (Brocki & Wearden, 2006; Smith, 2009).

2.4. Analysis of interviews

The analysis approach of the interviews was conducted using the six analytical steps of IPA (Smith, 2009). The study was inductive and concerned with exploring the participant's experiences with occupational-rehabilitation meetings and how s/he makes sense of the decisions at the meeting (Smith, 2009). IPA steps 1 and 2 included reading each interview transcription and developing a comprehensive and detailed set of comments on the interview transcriptions. Step 3 encompassed generating emergent themes, and step 4 involved searching for connections across emergent themes. In each interview, the emergent themes were allocated into superordinate themes. The final step involved looking for patterns across the interviews. At all steps, the authors tried to interpret and give meaning to the experience to which the participant attached meaning and interpretation (Smith, 2009).

2.5. Health literacy questionnaire

A validated Danish version of the Health Literacy Questionnaire (HLQ) was used to measure the participants' level of health literacy. HLQ is based on nine distinctive domains that derive from WHO's concept of health literacy (Osborne et al., 2013). The HLQ profiles were recorded after the IPA of the interviews had been completed, in order to avoid any possible influence of HLQ profiles on the IPA.

In order to standardize the method and to ensure the inclusion of people who cannot read, the interviewer read the questions in the HLQ to each participant.

3. Results

In the IPA of the data, six superordinate themes emerged: *the importance of the meeting; the experience of the structure of the meeting; the relationship to the social worker; the importance of an assessor; comprehension of information; and interaction with the occupational-rehabilitation team*. In Table 2, an explanation of the subthemes that underlie the six themes is included. The participants reported differences in their experiences with occupational-rehabilitation meetings. The superordinate themes and subthemes are presented in the following sections.

3.1. The importance of the occupational-rehabilitation meeting

The majority of participants attached great importance to the occupational-rehabilitation meeting. Three participants wanted to be allocated a reduced-hour job and they were fearful of being allocated an occupational-rehabilitation upgrading progression. The motivation for having a reduced-hour job was grounded in an ambition to get back to work because an attachment to the labour market had great influence on their self-image and sense of acceptance in society despite their illness. The reason why other participants did not ascribe any importance to the meeting was a limited understanding of the purpose of meeting or no previous attachment to the labour market and therefore no expectations of inclusion in it.

I was nervous that they would say that I was allocated an [occupational-rehabilitation upgrading progression] and that I should lose 20 kg and change myself completely [...] It is [at the occupational-rehabilitation meeting] everything was decided. This is where the rest of my working life would be decided

[...] I am 54, and at the time [of the occupational-rehabilitation meeting], 52 [years old], and had not worked for 15–20 years. So I said, "Who the hell can use me?"

3.2. The experience of the structure of the occupational-rehabilitation meeting

The occupational-rehabilitation team comprises 4–8 professionals, but for two participants this was remembered as up to 14–16 professionals. Five participants found the occupational-rehabilitation team's size overwhelming, and this affected their ability to interact with the team and led to a reaction of distress.

I thought it was okay. But I can easily see the resemblance to an examination situation, if you were more worried, because I was placed at the end of the table, like I was the birthday child or something like that. But that didn't bother me

Table 2. Presentation of superordinate themes and sub-themes

Superordinate themes	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5	Theme 6
	The importance of the occupational-rehabilitation meeting	The experience of the structure of the occupational-rehabilitation meeting	The relationship to the social worker	The importance of an assessor	Comprehension of information	Interaction with the occupational-rehabilitation team
Subthemes	The meeting has great importance for the person, as demonstrated by a specific expectation to the outcome of the meeting (P1, P2, P3, P4)	Positive attitude towards the structure of the meeting (P1, P5)	Positive relationship to and confidence in the social worker (P2)	Need for social support from spouse and professionals (P2, P4, P5, P6)	Lack of information (P1, P6)	Expectations of paternalism in the social sector and uncritical in interaction with professionals (P2, P3, P5)
	The meeting does not have a major impact on the person due to no specific expectation to the outcome of the meeting (P5, P6)	Anxiety about the meeting (P2)	Critical approach to the social worker's competencies (P1, P3, P6)	The assessor's importance for the interaction with the professionals (P3)	Limited ability to handle verbosity, and difficulties in understanding the information provided (P2, P4, P5)	Insecure in the interaction with the occupational-rehabilitation team (P3, P4)
		Uncomprehending of the structure of the meeting due to lack of information (P3, P6)			Little interest in seeking information related to the meeting (P3, P4)	

[...] there are so many people and it's all about you. It's not like it's a birthday party, where you sitting there like the birthday child. Well, it was overwhelming [...] I was simple so shaken and overwhelmed by the whole situation

3.3. The relationship to the social worker

The social worker is the only professional with whom the citizen has had contact before the occupational-rehabilitation meeting. For four participants, this contact had been disrupted by the replacement of their social worker up to several times during the preparations for the meeting. This led to mistrust towards the job centre as well as doubt about the social worker's competencies. One participant experienced the relationship to the social worker as positive because of the social worker's caring attitude towards the participant. The relationship to the social worker seems to be important for how the process is perceived—as either negative or positive.

Very unprofessional. There must be something wrong, since [the social workers], don't want to stay in their job. It's very unprofessional towards the people who need them. You know, that a new person has to interfere with your concerns all the time

They have kept an eye on me. I mean, I have called, and cried a lot, but she [the social worker] has just been able to handle all of it

3.4. The importance of an assessor

Citizens are allowed to bring a self-selected assessor to the occupational-rehabilitation meeting. Three of the participants used a family member as their assessor and two used an assessor from their trade union. One participant did not bring an assessor to the meeting. The participants reported a need for support from spouses and professionals because they were afraid that they would be unable to remember everything that would be said at the meeting. Some participants explained that

they became nervous when participating in such meetings, and therefore the spouse attended the meeting to provide social support.

I had my husband with me, and he has been with me through the whole process. Sometimes I have difficulty remembering and then two pairs of ears work a lot better

I had my son with me [...]. He joined the meeting because he was supposed to remember if something was said [at the meeting] that I was in doubt about, which I sometimes am at important meetings

One participant found it difficult to participate in the interaction with the occupational-rehabilitation-team, but found support in the assessor from the trade union, who helped make the participant feel more confident in the interaction and helped the participant to understand everything that was said at the meeting. Regardless of whether the assessor was a family member or from the trade union, this person had a very positive impact on participants' experiences of the occupational-rehabilitation meeting.

3.5. Comprehension of information

The participants reported differences in the amount of information provided before the meeting. For five participants, this led to unnecessary confusion about the impact of the meetings and the participants' own role in them. The information needs to be tailored to each citizen, as some participants have trouble reading written information, while others have trouble understanding and distinguishing between what information is relevant and what is not.

[...] if I had been given a pamphlet before the meeting, I would have had information beforehand, which I could have read so I knew what the meeting was about and what the consequences of the different actions were [...]

I was given something in writing, which I didn't understand one bit [...]. I have trouble understanding things. I have to have others read it for me

[...] but I couldn't handle all that information. If she had given it to me, I couldn't have used it for anything. I mean, what if I hadn't been given a reduced-hour job, then why the hell should I need to know anything about it?

3.6. Interaction with the occupational-rehabilitation team

The occupational-rehabilitation meetings are supposed to be dialogue based, with both the members of the occupational-rehabilitation team and the citizen having a say and deciding what is best for the citizen. Nevertheless, three participants felt that all responsibility was in the hands of the occupational-rehabilitation team. Three participants felt that the decision was made beforehand, and one participant therefore felt that it was unnecessary to take part in the meeting. The understanding of the participants' own role and ability to interact with professionals on equal terms appeared to influence the meeting. Despite different views on the interaction, all participants felt that the occupational-rehabilitation team was positive towards them, and all participants experienced being praised for their ability to handle illness and changed life circumstances.

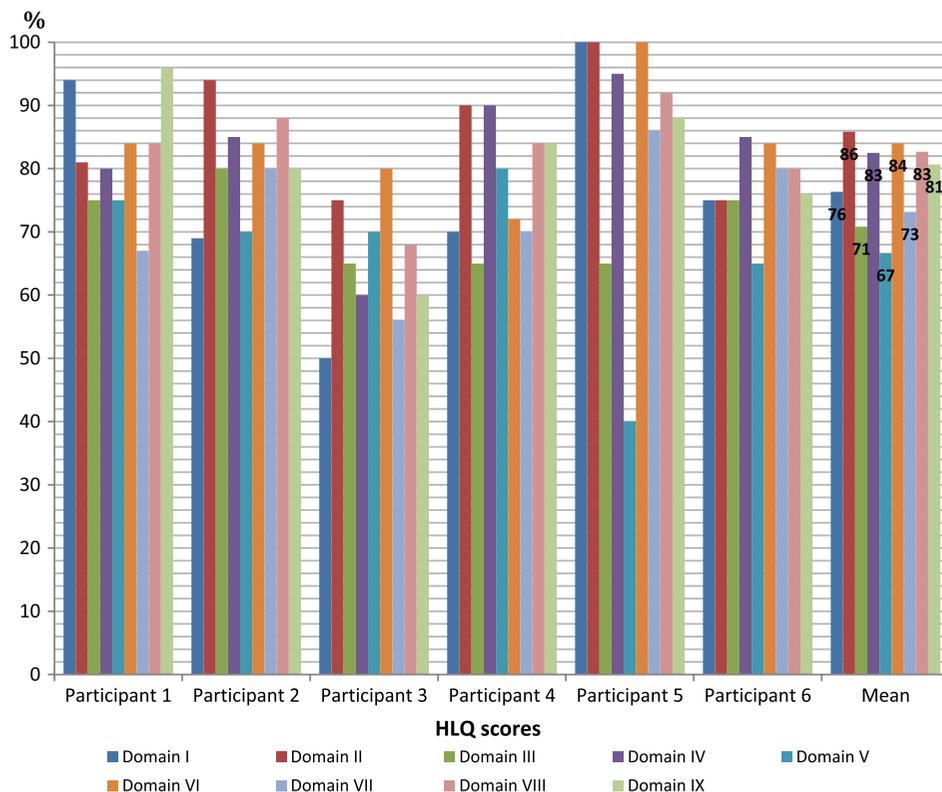
There was no dialogue; I mean, the teamwork is, "You do as we say". That's my perception of their way of doing teamwork

[...] and I must admit that I was very surprised, I'd say I almost couldn't believe it, because the doctor said numerous times that I was strong, and I thought that was nice to know

3.7. HLQ score results

All participants have large individual differences in their scores for each domain. This is most explicit for P5, who received a score of 100% in domains I, II and VI while getting a score of 40% in domain V. All participants assumed that they had great abilities in domain II: Having sufficient information

Figure 1. HLQ scores measured in all nine domains divided by participants and mean value.



to manage my health, but in domain V the participants scored somewhat lower compared with the remaining domains (Figure 1).

3.8. Superordinate themes and HLQ domains

The HLQ domains III and VII were not seen in connection with any of the superordinate themes. Four superordinate themes were linked to seven domains (Table 3). The domains that were related to the themes showed agreement between the participants' subjective experiences with the occupational-rehabilitation meeting and their HLQ score. All themes were relevant for all participants, despite the participants' different experiences and HLQ scores. Themes regarding social support, interaction with the professionals, and information can also be found in the seven HLQ domains. Those topics have significant importance in the consultation between citizens and professionals at the occupational-rehabilitation meeting.

For all participants, there was a strong relation between their experience of social support, both in everyday life and during the meeting, and their score in domain IV (Social support for health). For three participants, there were discrepancies between the score in domain I and their experience of support from their social worker. A discrepancy was also seen between the score in domain VIII and the participants' ability to find sufficient information about the occupational-rehabilitation meeting. Despite these divergences, an overall relation between the participants' experiences and their scores in the HLQ domains concerning information and interaction with the professionals was shown.

4. Discussion

The structure of the occupational-rehabilitation meetings enables the citizen to play an active role in the process of working towards an occupational related outcome. To ensure this, the communication must be accurate and at a level that the citizen can comprehend and therefore use. This basis for communication between citizen and professional is built upon the citizens' health literacy. Health literacy encompasses competencies in not only reading and writing information but also in appraising information and being able to interact with professionals. As the superordinate themes show,

Table 3. Relations between superordinate themes and HLQ domains

Superordinate themes										
1. The importance of the occupational-rehabilitation meeting	2. The experience of the structure of the occupational rehabilitation meeting	3. The relationship to the social worker	4. The importance of an assessor	5. Comprehension of information				6. Interaction with the occupational-rehabilitation team		
HLQ domains										
	I. Feeling understood and supported by healthcare providers	IV. Social support for health	II. Having sufficient information to manage my health	V. Appraisal of health information	VI. Ability to find good health information	VII. Understanding health information well enough to know what to do	VIII. Ability to actively engage with health care providers	III. Actively managing my health	VII. Navigating the healthcare system	

information, interaction and social support are crucial components of the participant’s ability to handle the health and social sectors. Measurement of health literacy can help social and health professionals to understand the capabilities of the individual citizen they are in contact with. A study by Batterham et al. (2016) addressed the fact that it is not necessary to analyze every patient’s health literacy; selecting data on a specific patient group with difficulties will help the health professional to better understand their patients in terms of health literacy issues (Batterham et al., 2016). The vulnerable situation of the citizens at the time of the occupational-rehabilitation meeting might also contribute to lower health literacy than at other times during the lifespan of the citizens (World Health Organization, 2013).

The results of this study show that seven of the nine domains were related to the participants’ experiences with the occupational-rehabilitation meeting. The HLQ domains that were affiliated with the participants’ experiences were those regarding information (domains II, V, VIII, IX), interaction (domains I and VI), and social support (domain IV). These topics have also been found to influence men and their spouses during active surveillance for prostate cancer (Kayser et al., 2015). As shown in Table 3, not all HLQ domains appeared in the IPA of the participants’ experience; furthermore, the HLQ used to measure health literacy in the given context seemed flawed. Two of the emergent themes appeared not to map onto the HLQ domains. The two themes: *the importance of the occupational-rehabilitation meeting* and *the experience of the structure of the occupational-rehabilitation meeting* are difficult to relate directly to health literacy. The HLQ domains used in the study have not been developed to measure health literacy issues that focus on a person’s beliefs or the contexts of a person’s life; non-generic HLQ domains that differ between contexts have been excluded from the questionnaire (Osborne et al., 2013). The two emergent themes can be understood as being specific to the context as well as being related to the participants’ personality traits and vulnerability at the time of the meeting, and these personal aspects will therefore not be made clear through the use of HLQ. This discrepancy between HLQ and these two emergent themes show that health care professionals must be aware of aspects that are specific to the given context. Furthermore, this could advocate for the inclusion in HLQ of domains that make it possible to elucidate aspects that are specific to different contexts in both the social sector and the health sector. Moreover, two of the nine domains did not appear to fit into the emergent themes. These were domains III (Actively managing my health) and VII (Navigating the healthcare system). This might be explained by the primary focus of the interview being narrowed down to the experience with the occupational-rehabilitation meeting.

The fact that HLQ is a generic questionnaire is both strength and a weakness in the context of the study. It seems that social support is a general tendency in people’s lives, in relation to not only health care but also other aspects of an individual’s life. The questions regarding domain IV are therefore indicators of the level of social support in the participant’s life and can probably be used in

this context. The generic aspect of HLQ can be difficult to find in other aspects of the questionnaire, which has been developed to be used across different sectors but nevertheless is based on a very narrow definition of professionals that does not include professionals from the social sector (e.g. social workers). This seems to have made the use of HLQ as a tool for measurement in this study problematic, as only interactions with health workers have been taken into consideration. Problems related to this could be solved if the introduction and explanation of the questionnaire were clarified.

In the study by Batterham et al. (2016), it is argued that some patients would be shown on the basis of the health literacy questions to not have any specific needs even though they in reality have great health literacy needs. A false negative is thus an important problem when using health literacy screening (Batterham et al., 2016). This finding can be understood in relation to how participant 5 was able to achieve a maximum score in two domains regarding information despite the fact that she said in the interview that she is not capable of understanding written information and also expressed difficulties in understanding the purpose of the occupational-rehabilitation meeting.

One of the great strengths of HLQ is that it can be used to create a health literacy profile that shows, which domains the individuals or group of individuals have strong or weak abilities in. Unlike other health literacy tools, it has been developed to both the population and the individual level. However, for it to be used accurately at occupational-rehabilitation meetings, the definition of professionals should be broader, and it might be worth considering whether some items of HLQ do not fit in entirely in a Danish context of occupational-rehabilitation. The superordinate themes may also be used as indicators of the citizen's strengths and weaknesses, as well as a way to understand the citizens' experience of the encounter. All the six superordinate themes are context specific and show which areas are of greatest importance for citizens after they have participated in an occupational-rehabilitation meeting. Professionals could take these areas into account, both before and during the meeting; this could be helpful in achieving the dialogue-based approach that is a cornerstone in the structure of the occupational-rehabilitation meeting. The knowledge of the individual's strengths as well as their vulnerability when they engage in the meeting would enhance the occupational-rehabilitation team's possibility to make the citizen an active part of their own future occupational capabilities.

4.1. Strengths and limitations

This study has a great strength in the fact that, despite there only being six participants, we have been able to identify superordinate themes and discover parallels and differences in the participants' experiences as well as differences in their health literacy. Future studies involving a larger number of participants would potentially support the qualitative findings and provide a wider range of health literacy profiles.

5. Conclusion

In the analysis of the interviews, six superordinate themes of the participants' experience with an occupational-rehabilitation meeting were found. The themes can be seen in relation to HLQ domains concerning interaction with professionals (domains I and VI), information (domains II, V, VIII, IX) and social support (domain IV). These relations were seen across the participants, and were not affected by the level of HLQ scores in the related domains. The HLQ scores varied across the participants and it was also shown that there were large differences within the individual HLQ profiles. Themes concerning the interaction and relationship with professionals, information and social support should be considered by professionals in the occupational-rehabilitation team in order to help enable citizens to play an active role in the occupational-rehabilitation meeting.

List of abbreviations

HLQ	Health Literacy Questionnaire
IPA	Interpretative Phenomenological Analysis

Author's contributions

Cecilie Mortensen and Lis Marie Pommerencke have equally contributed to the design of the study, conducted the field study and made the analysis. They have also written the first draft of the manuscript.

Lars Kayser has mentored the study and participated in the design and discussed results and analysis and has contributed to the second draft of the manuscript.

All authors have contributed equally to the final discussions and the final version of the manuscript.

Availability of data and material

The qualitative analysis was based on approximately six hours recordings of the interviews. All six interviews were fully transcribed in Danish.

The transcripts are available from the corresponding author upon request. The transcripts are not available on public sites to protect the anonymity of the participants.

Consent for publication

Consent to use the data material for this article was obtained in November 2015 by e-mail. All six participants gave consent hereto.

Ethics approval and consent to participate

In this study, there is no biological material involved, the participants are not subjected to any kind of diagnostics or treatment, and there are no medical devices included. Consequently acceptance from the National Committee on Health Research Ethics, Den Nationale Videnskabetiske Komite, is neither needed, nor obtainable, which is the case for all studies working with interviews and questionnaires. All data were handled according to the Danish Data Protection Law and were anonymous and it was therefore not required to register with the Danish Data Protection Agency. Written informed consent was obtained from the participants in the spring of 2015. The collection and handling of qualitative data was performed in accordance with the AAA Code of Ethics.

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Competing Interests

The authors declare no competing interest.

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