ОБЩЕСТВЕНИ КОМУНИКАЦИИ И ИНФОРМАЦИОННИ НАУКИ
PUBLIC COMMUNICATIONS AND INFORMATION SCIENCES

DIGITAL HEALTH COMMUNICATION AND HEALTH LITERACY: THEORETICAL MODELS AND INTEGRATIVE CONSIDERATIONS

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Abstract: *Digital media have become a central component of health communication. They influence users' information behavior and offer new opportunities to increase health literacy. At the same time risks arise, including misinformation and growing inequalities in access to health information. This publication presents theoretical models that explain user behavior in digital health contexts and highlight their limitations. The focus is on the Health Belief Model (HBM), the Theory of Planned Behavior (TPB) and the concept of the digital divide. While HBM and TPB analyse individual perceptions, attitudes and intentions, the digital divide addresses structural barriers. Recent research shows that digital health communication must also consider ethical, technological and trust-related dimensions. The rise of algorithmically mediated environments has introduced new challenges regarding transparency, fairness and accountability (Stark et al. 2023; World Health Organization 2023). These developments have led to the notion of an algorithmic health divide, extending traditional understandings of inequality by including disparities in algorithmic literacy and data governance (Okan et al. 2024). Trust and ethical data handling have therefore become key determinants of users' engagement. Combining psychological, structural and ethical perspectives offers a foundation for inclusive, trustworthy and evidence-based digital health communication that strengthens health literacy and equity.*
Keywords: *digital health communication; health literacy; digital health literacy; Health Belief Model; Theory of Planned Behavior*

INTRODUCTION

Digitalization has fundamentally changed health communication. Digital channels increasingly determine how people search for, evaluate and apply health-related information. This development opens up opportunities for low-threshold access and personalized support but also brings challenges: information overload, the viral spread of misinformation and the reinforcement of social inequalities in access to health information (Cinelli et al. 2020; Deursen and Helsper 2015). At the heart of these developments is health literacy, understood as the ability to acquire, understand, critically evaluate and apply information to make decisions (Sørensen et al. 2012). With increasing digitalization, the broader concept of digital health literacy is gaining in importance. This term describes the ability to navigate digital information environments safely and critically (Norman and Skinner 2006). Recent studies indicate that older people and socially disadvantaged groups in particular have low digital health literacy and may therefore be excluded from using digital services (Dratva et al. 2024).

Digitalization has led to the emergence of new communicative environments that are no longer exclusively human-mediated. Automated systems, algorithms and artificial intelligence now play an active role in shaping how health information is filtered, prioritised and displayed. These technologies have introduced an additional layer of complexity: while they can personalise and accelerate access to relevant content, they also raise new ethical questions about transparency, data use and accountability (World Health Organization 2023). Consequently, the issue of trust has become a core determinant of digital health communication, influencing how individuals assess information credibility and decide whether to act upon it (Stark et al. 2023). A theoretical foundation is necessary to better understand these challenges. Classic approaches such as HBM and TPB offer

useful frameworks for explaining individual behavior. They take into account perceptions of risk, attitudes, social norms and perceived behavioral control. Yet these models have traditionally focused on individual cognition and motivation, often overlooking broader structural or ethical contexts. The concept of the digital divide fills this gap by systematically explaining barriers such as lack of access, limited digital skills or low motivation (Van Dijk 2005). Recent scholarship extends this idea toward an algorithmic health divide, which captures new forms of inequality emerging from opaque data-driven systems and differences in algorithmic literacy (Okan et al. 2024).

Comparing these theoretical models and evaluating their relevance for digital health communication should contribute to establishing a coherent research field that connects behavioral, social and ethical perspectives. This is equally important for communication science and public health. By integrating classical behavioral theories with current concepts such as digital trust, algorithmic transparency and participatory design, research can develop a more comprehensive understanding of digital health literacy and its implications for equity and empowerment. Only such an integrative approach can ensure that digital health communication is effective, evidence-based and socially inclusive.

RESEARCH METHODOLOGY

The research methodology applied in this publication is primarily based on a structured literature analysis. The objective was to systematically identify and evaluate theoretical models relevant to digital health communication and to assess their applicability for the promotion of health literacy. The analysis was not limited to a single discipline but deliberately combined perspectives from communication science, public health, psychology and information science in order to capture the multidimensional character of the research problem (Snyder 2019).

A systematic search was conducted in recognized databases such as PubMed, Scopus and Web of Science. In addition, key reports by international organizations were integrated to incorporate policy-relevant insights. Inclusion criteria were peer-reviewed publications that explicitly address theoretical models or digital health literacy. Data were analyzed using a comparative approach. Each study was coded with respect to its theoretical basis, methodological design, target group and reported outcomes. Constructs such as perceived risk, attitudes, usability and structural inequalities were systematically compared across frameworks. To increase reliability, the evaluation followed elements of qualitative synthesis as outlined by Noblit and Hare (1988), while quantitative results from population surveys were integrated descriptively. Quality assurance was ensured by applying established standards. Only studies that reported transparent methods and adhered to recognized ethical guidelines were included. For quality appraisal, checklists such as the Mixed Methods Appraisal Tool (MMAT) were considered where applicable (Hong et al. 2018). This was particularly relevant for studies involving vulnerable groups such as older adults or individuals with low digital literacy.

The results of the literature analysis were synthesized in a way that highlights complementarities and limitations of the different frameworks. By triangulating evidence from theoretical, empirical and policy-related sources, the methodology provides a robust foundation for the integrative perspective proposed in this article.

RESULTS

Context, media logic and individual competence strongly influence the dialogical process of health communication. Health literacy in particular is considered a decisive factor: it describes the ability to identify, understand, critically evaluate and apply health-related information to decision-making (Sørensen et al. 2012). With digitalization, the focus has shifted to digital health literacy. In addition to traditional information processing this also includes the ability to use digital media safely, critically and responsibly (Norman and Skinner 2006).

Recent studies show significant deficits in the population: large sections of the population have only low digital health literacy in Germany, which limits their participation in digital services (Dratva et al. 2024). Similar findings have been reported internationally, with comparative surveys

highlighting substantial gaps between younger, digitally literate groups and older or socioeconomically disadvantaged populations (Levin-Zamir and Bertschi 2018; Dadaczynski et al. 2021). HBM explains health-related behavior based on factors such as susceptibility, severity, perceived benefits, barriers, incentives and self-efficacy (Becker 1974; Rosenstock 1974; Glanz et al. 2015). In the digital context, its significance can be seen, for example in applications or internet portals that support protective behavior by means of personalised risk information and can reduce barriers through targeted communication (Seale et al. 2020). The model has also been applied to the evaluation of digital vaccination reminders and COVID-19 exposure notification systems, where perceptions of susceptibility and severity significantly shaped uptake (Shmueli 2021). TPB explains behavior through intentions that are shaped by attitudes, social norms and perceived control (Ajzen 1991). Its relevance is evident in digital health communication as trust, social pressure and digital literacy have a greater influence on the use of tools than mere technical access (Tomczyk et al. 2021). Recent extensions of TPB further integrate affective attitudes and perceived credibility of digital platforms, showing that misinformation or lack of transparency reduces intention to use eHealth solutions (Çelik 2023). The concept of the digital divide shows that technological innovations remain unevenly distributed and are reflected not only in access but also in skills, usage and outcomes (Van Dijk, 2005; Scheerder et al. 2017).

In the health sector in particular, vulnerable groups such as older people or those with low levels of education are disadvantaged and use digital information less frequently and less critically (Friemel, 2016). More recent scholarship emphasizes the notion of a health data divide, highlighting inequities not only in information access but also in participation in digital health data ecosystems, such as electronic health records and patient portals (Veinot et al. 2018).

The models complement each other. The HBM explains individual risk perception and motivation, the TPB highlights social influences and perceived control. The digital divide reveals structural barriers. An integrative view of these approaches allows both micro psychological determinants (attitudes, intentions, self-efficacy) and macro-structural conditions (access, competence, social inequality) to be taken into account. This establishes a theoretical framework for the practical development of target group-oriented and inclusive digital health communication. In this context, approaches such as the Unified Theory of Acceptance and Use of Technology (UTAUT) and Technology Acceptance Model (TAM) have also proven valuable in explaining adoption behavior, particularly when combined with health-specific frameworks (Venkatesh et al. 2012; Marangunić and Granić 2015).

A comparative analysis of the three theoretical approaches shows that each model has specific strengths, but that only when combined do they provide a comprehensive picture of digital health communication. The HBM is suitable for explaining individual risk perceptions and willingness to act in a digital context. Studies show that digital tools such as vaccination apps or online risk tests are effective when they highlight individual susceptibility and the severity of diseases (Jones et al. 2015; Seale et al. 2020). At the same time, it is clear that perceived barriers such as a lack of trust in data and information security limit their use. The TPB emphasizes the role of social norms and perceived behavioral control. Empirical findings on the use of digital health apps show that acceptance depends less on access and more on trust, social pressure and one's own digital competence (Ajzen and Schmidt, 2020; Tomczyk et al. 2021). The TPB thus explains why certain groups do not use digital health services despite the technical possibilities available. The digital divide approach extends psychological models to include structural dimensions. The analysis shows that differences in access and competence lead to systematic disadvantages for vulnerable groups. These differences have a direct impact on health literacy and can exacerbate health inequalities (Friemel, 2016; Scheerder et al. 2017). The study illustrates that HBM and TPB offer important lessons at the individual level. The impact of digital, complex health communication can only be fully understood when the digital divide is taken into account. In addition, more recent integrative research highlights that intersectional factors such as gender, migration background and regional disparities play an increasingly important role in shaping both access to and use of digital health services (Robinson et al. 2015).

Addressing these factors is essential if digital health strategies are to reduce rather than reinforce inequalities. Beyond these theoretical perspectives, recent research highlights the increasing importance of digital health engagement as a multidimensional construct that bridges psychological, social and structural determinants. Empirical analyses confirm that digital health literacy acts as a mediating variable between socio-economic background and the effective use of eHealth services (Nguyen et al. 2023). In this sense digital competence not only facilitates access but also enhances perceived behavioral control, a central element in the TPB (Ajzen 1991). Studies further show that individuals with higher trust in institutions and stronger perceptions of data transparency demonstrate greater willingness to share health information digitally (Stark et al. 2023). At the same time new conceptual frameworks propose that trust and engagement are dynamic processes rather than stable attributes. The Digital Health Engagement Framework identifies interaction quality, perceived fairness and adaptive feedback mechanisms as crucial drivers of sustainable participation (Baumgart et al. 2023). These findings support the assumption that psychological models such as HBM and TPB must be complemented by feedback-oriented and ethically grounded approaches in order to capture the iterative nature of digital health behavior. Moreover, the results of comparative cross-country surveys reveal growing inequalities in algorithmic health communication. While algorithmic recommendation systems can increase perceived relevance, they also risk reinforcing pre-existing social divides when transparency and user agency are insufficient (Okan et al. 2024; Veinot et al. 2018). The inclusion of algorithmic fairness and explainability as structural dimensions therefore extends the original concept of the digital divide toward what has been termed an algorithmic health divide. This notion integrates questions of accessibility, autonomy and justice into the analysis of digital health communication.

Several studies emphasize that participatory design and co-creation improve both usability and perceived empowerment, especially among older adults or groups with limited digital literacy (Toloza et al. 2024; Bernaerts et al. 2024). Participation thus emerges as a cross-cutting dimension that connects psychological motivation with structural inclusion. These insights demonstrate that effective and equitable digital health communication requires the systematic integration of behavioral, structural and ethical perspectives within one coherent analytical framework.

CONCLUSIONS/DISCUSSION

This analysis has shown that theoretical models make an indispensable contribution to understanding digital health communication. HBM explains how individual risk perception, benefit assessment and self-efficacy influence behavior in digital contexts. TPB supplements this perspective with social norms and perceived behavioral control, which are crucial for the acceptance of digital health applications. Only by considering the concept of the digital divide does it become clear that structural barriers such as lack of access, insufficient skills or lack of motivation can severely limit the use of digital offerings (Ajzen 1991; Sørensen et al., 2012). Only the combination of psychological and structural models enables a realistic assessment of the opportunities and limitations of digital health communication. Individual models are not comprehensive. HBM neglects social norms, TPB neglects structural barriers and the digital divide does not take individuality into account. The extension of these frameworks with additional perspectives further strengthens explanatory power. The incorporation of TAM and UTAUT highlights the importance of usability, effort expectancy and facilitating conditions for the adoption of digital health technologies (Venkatesh et al. 2012; Marangunić and Granić 2015). Intersectional analyses show that factors such as gender, migration background and regional inequalities interact with psychological determinants and structural divides to produce multi-layered barriers (Robinson et al. 2015).

Addressing these complexities requires integrative frameworks that move beyond isolated models and systematically combine behavioral, social and technological dimensions. Such an approach has clear implications for practice and policy. On the one hand, the design of digital offerings must be target group-specific, barrier-sensitive and grounded in evidence-based models. Strategies such as participatory development and co-design with vulnerable groups are essential to foster trust and increase acceptance. On the other hand, policymakers must ensure equitable access

and provide the necessary infrastructure and training programs to reduce digital inequalities. The promotion of digital health literacy, particularly among older adults, socioeconomically disadvantaged groups and those with limited language skills, emerges as a key lever for reducing disparities (Dratva et al. 2024; Levin-Zamir and Bertschi 2018).

For future research, it is necessary to conduct empirical studies that jointly operationalise these models and test them in different population groups. Mixed-methods designs and longitudinal analyses would allow a more comprehensive understanding of how attitudes, norms and digital skills interact with structural conditions over time. Greater attention should be paid to the role of credibility and trust in digital environments, given that misinformation and algorithmic bias significantly affect health behavior (Çelik 2023; Veinot et al. 2018).

Building on these findings, current research underlines that digital trust and ethical governance are now key determinants of sustainable participation in digital health communication. Trust must be understood not as a static construct but as an evolving relationship between users, technologies and institutions (de Camargo Catapan et al. 2025). Its development depends on transparency, data integrity and fairness in algorithmic decision-making. When users perceive a lack of control or are uncertain about how data are used, trust declines sharply, even when usability is high (Stark et al. 2023). Conversely, clear communication about data protection policies and participatory design processes significantly enhances users' confidence and willingness to engage.

Ethical frameworks have become increasingly relevant to address these challenges. The World Health Organization's Guidance on Ethics and Governance of Artificial Intelligence for Health (2023) explicitly calls for principles such as explainability, accountability and human oversight in digital health technologies. Without these safeguards, algorithmic systems risk reinforcing the very social inequalities that digitalization aims to mitigate. Integrating ethical and governance dimensions into existing models (HBM, TPB, TAM) expands their predictive and normative value, linking behavioral motivation with fairness and responsibility (Okan et al. 2024). Another essential dimension is participation. Empirical studies indicate that co-design and participatory research significantly improve user acceptance, perceived empowerment and long-term engagement (Bernaerts et al. 2024; Toloza et al. 2024). Participation thus transforms digital health communication from a one-directional information process into an inclusive dialogue that enhances digital health literacy and equity. Participatory models also operationalise social capital, showing that engagement in digital communities promotes both trust and resilience against misinformation (Baumgart et al. 2023). Recent approaches, such as the Digital Health Engagement Framework and the Digital Health Literacy Maturity Model (Nguyen et al. 2023), highlight the interplay between digital competence, motivation and system design. These models confirm that health literacy mediates between socio-economic position and digital engagement, reinforcing the need for capacity-building interventions at community level. The concept of an algorithmic health divide broadens the understanding of inequality beyond access, focusing on fairness, transparency and the distribution of algorithmic risk (Okan et al. 2024).

These findings underline from a policy perspective that digital inclusion requires more than infrastructure. It must also ensure informational justice and user agency. National digital health strategies should therefore institutionalize trust audits, ethical impact assessments and participatory design guidelines (World Health Organization 2023). Embedding these measures in governance frameworks ensures that digital transformation in health communication aligns with values of fairness, inclusion and accountability. The convergence of behavioral, structural and ethical perspectives points towards a comprehensive integrative model of digital health communication. This model acknowledges that cognitive, social and algorithmic environments co-shape health behavior in digital contexts. By systematically linking user psychology, technology design and governance ethics, such a framework offers a foundation for both research and implementation. It shows that digitalization in healthcare can only reach its full potential when it informs and empowers. Digital health communication must therefore be designed to be trustworthy, inclusive and equitable.

In conclusion the synthesis of behavioral, structural and ethical dimensions demonstrates that digital health communication cannot be understood as a purely technological process or as an in-

dividual act of information seeking. It represents a socially embedded and normatively significant practice that depends on trust, literacy and transparent governance. Strengthening digital health literacy therefore requires not only educational efforts but also systemic measures that promote equitable access, participatory design and institutional accountability. Future frameworks in research and policy should integrate these elements to ensure that digital health transformation contributes to empowerment and health equity rather than reinforcing existing disparities. Sustained interdisciplinary collaboration between communication science, public health and information technology is essential to achieve this goal and to establish digital health communication as a credible, inclusive and ethically grounded field of practice.

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ЦИФРОВА КОМУНИКАЦИЯ В ОБЛАСТТА НА ЗДРАВЕОПАЗВАНЕТО И ЗДРАВНАТА ГРАМОТНОСТ: ТЕОРЕТИЧНИ МОДЕЛИ И ИНТЕГРАТИВНИ СЪОБРАЖЕНИЯ

Резюме: *Цифровите медии са се превърнали в централен компонент на комуникацията в областта на здравеопазването. Те влияят върху информационното поведение на потребителите и предлагат нови възможности за повишаване на здравната грамотност. В същото време възникват рискове, включително дезинформация и нарастващи неравенства в достъпа до здравна информация. Тази публикация представя теоретични модели, които обясняват поведението на потребителите в цифровия контекст на здравеопазването и подчертават техните ограничения. Акцентът е върху модела на здравните вярвания (HBM), теорията за планираното поведение (TPB) и концепцията за цифровото разделение. Докато HBM и TPB анализират индивидуалните възприятия, нагласи и намерения, цифровото разделение се занимава със структурните бариери. Последните проучвания показват, че цифровата комуникация в областта на здравеопазването трябва да взема предвид и етичните, технологичните и свързаните с доверието измерения. Възходът на алгоритмично медиираните среди е донесъл нови предизвикателства по отношение на прозрачността, справедливостта и отчетността (Stark et al. 2023; Световна здравна организация 2023). Тези развития водят до понятието за алгоритмична здравна пропаст, което разширява традиционното разбиране за неравенството, като се включват различията в алгоритмичната грамотност и управлението на данните (Okan et al. 2024). Доверието*

и етичното боравене с данни са се превърнали в ключови фактори за ангажираността на потребителите. Комбинирането на психологически, структурни и етични перспективи предлага основа за приобщаваща, надеждна и основана на доказателства цифрова комуникация в областта на здравеопазването, която укрепва здравната грамотност и равенството.
Ключови думи: *цифрова комуникация в здравеопазването; здравна грамотност; цифрова здравна грамотност; модел на вярвания за здравето; теория на планираното поведение*

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