Health education and its place in the evolving medical systems is the basic theme of this presentation. The role of the patient education, what it means, and how it can be advanced are discussed.

Health Education Horizons and Patient Satisfactions

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Justification and means for improving health services in our country have been offered for many years but with good reason, never in such numbers and variety, and with such intensity as today.

In all instances, whether the recommendations emerge from citizen concern, the scholarly efforts of individuals or special study groups, or from service programs, experiment and demonstration, the broad goal embraces the concept of better health for people.

Becoming more specific, concerns are expressed for particular population groups or for systems of health care with certain characteristics. Among these characteristics are "comprehensiveness," "a focus on preventive medicine," and "patient satisfaction."

Those among health workers who have long been occupied with the education components in all aspects of health-related activities are fully aware of how teaching-learning needs and potentials are imbedded in each of the areas these three characteristics identify. This appreciation is sometimes shared, with varying degrees of sophistication, by planners and administrators. It is also sometimes expressed overtly through mention in published medical care analyses and recommendations, and through financial support for education activities in operating agencies.

If the future shape of our "health industry," evolving at today's accelerated pace, is to include, among many other characteristics of course, *comprehensive care* extending to rehabilitation and living with disability, *a focus on preventive medicine*, extending to continuing as well as one-time patient behaviors, and *patient satisfaction* extending to all relationships with a health care agency along the entire continuum of health-illness-health, then today's planners and experimenters may have to deepen and expand their concerns with education in the organization and functioning of health services' agencies. Health educators obviously must share in this effort.

There do exist proposals which recognize the direction we hope to follow. There are also a considerable number of programs, in quite varied settings, where beginnings and precedents have been well-established by educators. A look at several of these proposals and a reminder of what we mean by education, may serve to indicate where we have been, where we are, and maybe what can be done to assure, if not to speed the future.

Within the past four years, five statements reflecting the interest and involvement of the federal government, and one document sponsored by the APHA and the National Health Council are of relevance. Looking at government first, in 1964 an *Advisory Committee on Health Education and Communications* was created "for the purpose of advising the (Public Health) Service on improving and intensifying the education-communication component of our programs to facilitate the fuller use of available knowledge." During the year following its formation, the nationally-drawn Committee of nineteen met six times and the staff arranged 13 panel discussions in different parts of the country. In addition, there were many individual interviews and a mail survey. The final report is called "Education for Health" and was published by the Public Health Service in 1966.[1]

The Report explains how "the application of medical knowledge is, to a unique degree, the sum of separate individual decisions and actions by professional and non-professionals alike," and that, "If these decisions and actions are to be sound they must be based on appropriate understanding, attitudes, and skills."

Three among the 13 recommendations are as follows:

"*Recommendation 1*: That skills and knowledge of health education, public information, and other communications' specialists be incorporated at every appropriate stage of program planning and policy development throughout the Public Health Service.

"*Recommendation 5*: That the Public Health Service support demonstration projects for improved use of educational science and technology in health programs for both the professions and the public.

"*Recommendation 8*: That the Public Health Service create a formal mechanism designed to assure that research findings generated by its behavioral science program are translated systematically into operating practice by the programs concerned."

Another report was prepared when the Senate Committee on Finance asked the Secretary of Health, Education, and Welfare to submit to Congress by January 1, 1969 the results of studies on "the possible coverage under Medicare of the cost of comprehensive health screening devices and preventive services designed to contribute to the early detection and prevention of diseases in old age and the feasibility of instituting and conducting informational or educational programs designed to reduce illness

among Medicare beneficiaries and to aid them in obtaining needed treatment."

A 14-member *Advisory Committee on Health Education* was formed to focus its attention on the latter half of the charge. Substantial parts of its report, "Education and Medicare"[2] were incorporated into the Secretary's Report to Congress entitled "Feasibility Study on Preventive Services and Health Education for Medicare Recipients,"[3] submitted in December, 1968.

The fuller staff report, in recommending that the federal government act to strengthen local education activities to reduce illness among Medicare beneficiaries included a 4-part "Action Plan." The first part states, "Amend the conditions for participation in Medicare to require that hospitals, extended care facilities, and home health agencies include qualified educational specialists on their staffs or use qualified consultants to help insure that educational components of their services are soundly developed." The Secretary's report recommends:

> 1. That a national, cooperative, voluntary effort directed at health education for the aged should be initiated by the DHEW in cooperation with medical societies, women's auxiliaries, voluntary agencies, advertising groups, consumer groups, senior citizen's organizations, community hospitals and other providers of services, public health agencies, insurance companies, news media and other groups interested in and capable of providing local leadership, initiative and effective action. To accomplish this, it will be necessary that:
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> a) Congress provide appropriations for the activity;
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> b) The Department provide an effective focal point for the coordination of health education efforts in the Office of the Assistant Secretary for Health and Scientific Affairs.

A third federal publication of interest here is entitled "Provisional Guidelines for Automated Multiphasic Health Testing and Services. Vol. 2, Operational Manual," published in July, 1970 by the Health Services and Mental Health Administration.[4]

In the section, "General Quality Guidelines for Planning AMHTS," the authors explain that while no quality guidelines for research and teaching are included, "consideration must be given to: (1) Patient health education and counseling, (2) Health professional orientation in preventive and predictive medicine."

There is a substantial section in the Manual, entitled "Adjunctive Services to AMHTS," which discusses health education at some length. In this section it is stated, "patient health education will be especially useful," and that its objectives are twofold: "(1) to acquaint the examinee with the screening programs as regards the kinds of tests which will be done and the importance of following up on the results; and (2) to provide general health education and counseling regarding preventive medical measures." Further elaboration includes these statements:

> "While some patient education may be possible through the use of literature, pamphlets, etc., all effort should be made for direct teaching contact.
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> "Facilities, including explanatory literature and visual displays should be available for the examinees, and personnel should be present to answer any questions.
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> "A shift in emphasis is developing from the traditional treatment of the sick, to a purposeful plan for keeping people well, using facilities especially designed for the promotion of health.
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> "The personnel required for the overall health education phase will be dictated by the specific type of program, but the services of at least a professional health educator would be desirable."

A fourth document is the *Report of the Task Force on Medicaid and Related Programs*, submitted to the Secretary of Health, Education, and Welfare about four months ago.[5] This eminent Task Force, chaired by Walter J. McNerney, assisted by a high-level staff, defined its scope of inquiry broadly, for as it explains, "neither the purposes nor design of government programs can be comprehended adequately in today's environment without reference to the health system as a whole." The Report adds, "If sufficient changes in effectiveness and efficiency are to be achieved, much bolder interventions will be needed than we have seen to date. These must be in the form of public policy reinforced through more aggressive management." Also, "The concept of planned intervention can be organized in three interacting and interdependent categories: more responsible purchase of services, better management of health services, and broader concept of health care."

In the discussion of this broader concept, the Report states, "Currently, the health care system is geared primarily to care for acute illness. This is a distortion of investment in both economic and human terms. A better balance, with heavy emphasis on primary care to prevent illness, is needed and frequently cited."

Then, while explaining that "A basic tenet of the Report is that greater consumer involvement in decision-making is required to overcome deficiencies in the health system . . . ," The Task Force "underscored the desirability of instructing users of services on their rights and benefits and how to best use available services.

"Programs of health education," the Report continues: "provided they meet adequate standards set by the Federal Government, should be considered integral components of any health care service and, therefore, included in the budget of such service. All agencies and institutions providing health services that receive Federal support must provide continuing programs of health education to their consumers."

"State Medicaid Programs should be required to undertake educational efforts designed to: improve recipients' use of the Medicaid program; improve the health of Medicaid recipients through preventive education; improve providers' use of the program; and provide for greater participation by provider and consumer in the planning, implementation, and evaluation of the program.

"In order to assist State Medicaid Programs in developing effective educational and informational programs, guidelines, materials, consultation and technical assistance should be provided by HEW. 'Model educational programs' should be developed in consultation with the States. The approach used should also include 'outreach' education utilizing potential Medicaid beneficiaries. Efforts should be made to involve voluntary health agencies, consumer organizations and professional organizations, many of which have substantial and successful health-education experience."

The last governmental document being noted here, is the most recent. On August 27, 1970 Senator Edward M. Kennedy introduced a bill (S4297), cited as "The Health Security Act." His introductory speech, the bill itself, and a section-by-section analysis are printed in the Congressional Record.[6]

The Health Security Act is based on the recommendations of the Committee for National Health Insurance which was formed by Walter Reuther, and which includes in its membership three Senators in addition to Mr. Kennedy, and nearly 100 other prominent Americans. Its technical sub-Committee is chaired by Dr. I. S. Falk.

The Act is comprehensive and extensive. In summarizing its main provisions, Senator Kennedy said, "The benefits of the program are intended to embrace the entire range of services required for personal health, including services for the prevention and early detection of disease, for the care and treatment of illness, and for medical rehabilitation.

"It will encourage the use of personnel in short supply. It will stimulate the progressive broadening of health services."

In the Part B of the Bill, "Nature and Scope of Benefits: Covered Services: under Sec. 27 (a) the listing of covered services includes:

> "(b) Supporting services (such as psychological, physiotherapy, nutrition, social work, or health education services) are covered services when they are a part of institutional services or when with the approval of the Board they are furnished by a comprehensive health service organization,"

which meets certain requirements. In a later section (Sec. 47) a comprehensive health service organization is defined as a qualified provider of covered services if, among other requirements,

> "(g) the organization encourages health education of its enrollees and the development and use of preventive health services . . ."

The program policy Board is authorized "to appoint standing committees to advise on the professional and technical aspects of administration with respect to services, payments, evaluations, etc." and this is explained to include the covered supporting services, of which health education is one.

Section 131 contains "one of the bill's most important provisions with respect to achieving improvement in coordination, availability, and quality of services," Mr. Kennedy explains. "The Board is authorized to issue a direction to any participating provider . . . that as a condition of participation, the provider add or discontinue one or more covered services."

All these references to health education in the five governmental documents mentioned, exhibit varying degrees of understanding or commitment. However characterized, that they exist at all, is a tribute to the professional achievements of many educators in service programs and research, and to their participation in the analyses and discussions which led directly to these formulations. Efforts to elaborate standards and guidelines for the educational components in any health care system, and to assure their inclusion in planning and operations must of course continue–even in the face of current minimal, rather than great expectations.

As Dr. James R. Kimmey, Executive Director of the APHA, recently put it, "Years ago, the professionals outside and inside of government looked at health problems, made suggestions, and made decisions. Today it's not professional judgment but political judgment that's being used to develop health programs."[7] He explained that in the federal budget both the amount of money allocated and the emphasis on health are "tied to national priorities as well as to priorities within the health structure itself." "Health," he said, "has been politicized in this country to an extent unknown in the past."

The non-governmental national document referred to earlier is the report issued in 1966, entitled *"Health is a Community Affair."*[8] This volume is the report of the National Commission on Community Health Services, a private corporation sponsored by the APHA and the National Health Council. Among its "positions" and recommendations, after four years of work involving many leaders in public health, is one concerning health education.

> "Education for health is a fundamental aspect of community health services and is basic to every health program. It should stimulate each individual to assume responsibility for maintaining health through life and to participate in community health activities. The community has a responsibility for developing an organized and continuing educational program concerning health resources for its residents. Each individual has a personal responsibility for making full use of available resources,"

The report was presented "To the People of the United States . . . in the full knowledge that quality health services for all the people will require responsible action by individuals, by communities, and by health agencies serving in every dimension of public and private life."

Prior to and along with the preparation and publication of the reports mentioned, and continuing today are the efforts of health educators in a multitude of settings. These educators are concerned with newer objectives and techniques as well as more traditional goals and methods. Some stress experiment and research. Their interests range from transactions between doctor and patient in acute health emergencies through the training and supervision of aides and the environmental influences on health, to planning and administration. They have always been involved with preventive medicine and the promotion of health.

As in every profession today, there are internal questions. How shall the educator's knowledge and skills best be used? What are our social and professional priorities? How can formal education programs be adapted to fill manpower needs? How can necessary research and experimentation be encouraged? Today also, it may be appropriate to stress again that a belief in the value of the education of the individual, and in the study of individual behavior, must not be taken to mean a belief that it is possible to divorce such behavior from its social base.

What educators have already demonstrated however, and are currently doing across the country, is reason enough for the health systems emerging in response to social needs and pressures to incorporate health education

in their planning and operations in a more than superficial manner. The educator's role in furthering this end is obviously to continue to extend and improve his activities, to translate his knowledge and experience into guidelines and standards others may adopt, and to demonstrate again and again that educational programs conceived primarily in terms of pamphlets and posters are primitive indeed.

A year ago, at a national conference on health education in the hospital, Dr. Scott K. Simonds read a paper which is germane to the topic under discussion in many ways.[9] Speaking for professional health educators, Dr. Simonds suggested that an ethos of patient education had evolved, and he summarized it as consisting of six points of development in a value system centering on the patient:

"1) He shall be respected and cared for as a human being.

"2) He shall be recognized as having a unique sociopsychological, cultural, and familial background relevant to his condition and to communication with him concerning his condition.

"3) He shall have access to and the opportunity to obtain the information and guidance that he sees as needed to care for his condition and shall have the support for helping him use the information obtained.

"4) He shall be provided an active and participatory role in his own care to the extent that he chooses and is able.

"5) He shall be stimulated and guided through effective educational means to acquire new knowledge, attitudes, and actions that will promote his ability to care for himself more adequately and to maintain his health at an optimum level; and

"6) He shall be cared for through services designed and organized to promote and support learnings and behavior that are appropriate to his care and to the maintenance of his health."

Dr. Simonds added, "It seems to me we now hold these truths to be self-evident."

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