CHAPTER SIX

6.0 ESSENTIAL NATURE OR FUNDAMENTAL CHARACTER OF HEALTH EDUCATION

Underlying professional thought and work are certain assumptions, hypothesizes, and beliefs about the meaning of ideas. These form the philosophic base of any profession. The questions are these: what is health education? What is its substance and nature? How is health education including by or distinguishing from discipline such as nursing, patient education, hospital administration, medicine, physical education/psychology, physiology and sociology?

To attempt to answer these questions, it is essential that we first seek an application and understanding of the idea of health in simple terms. What do you believe about health? What does the term really mean? Etymological health is derived from the Anglo-Saxon word 'health' meaning safe, sound or whole. In a number of languages, 'health and wholeness' as well as 'health and holiness' are etymologically linked. Over the years health has a variety of meanings including freedom from disease and quality of life. Traditionally, health was viewed as physical well-being and as a process, instead of a condition and as concept with physical, social, emotional, and spiritual dimensions.

The first attempt to rectify the limitations of defining health in the physical sense alone was made by the World Health Organization (WHO) which defined "health as a state of complete physical, mental and social well being and not merely the absence of disease or

infirmity"[84] Jesse Williams, a professor thinker in the 1930s, "observed that health as freedom from disease is a standard of mediocrity, health as the quality of life is a standard of inspiration and increasing achievement"[85]. Relating health to quality of life was a dramatic departure from the traditional thought of enlightened scholars such as Dubois Hoymar and Duna, resulting in more comprehensive philosophic interpretations of the meaning of health. Hoymar expresses his contemporary view of health as:

> "A person wants health as a means of living the kind of life and striving towards the kinds of goals that he sets for life. Only the health crank or hypochondriac values health as end in itself. A true healthy person will sacrifice his physical health and if need be his life, for values he considers greater than himself"[86]

In line with this thinking, it is the general agreement among health educators that emphasizing increased life span as an indicator of health is insufficient and that the quality of life of a person experience is for more important than longevity. Health is now considered one means of achieving a full life. According to Webster dictionary, a definition is "A word or phrase experiencing the essential nature of as person or thing". It sounds simple enough, but capturing in a word or phrase the essential nature of what we call health is very difficult and perhaps not very useful task"[87]. So explained Carlyon when describe health as I see it, rather than define it. "Before stepping off into that realm of speculation, social science, and sentiment wherein we customarily grope for meaning for the world health it might be useful to separate the health territory from the advanced territories with which it is frequently

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[84] WHO in Laurna Rubinson ibid
[85] Jesse William in Laurna Rubinson ibid
[86] Hoymar A. et.al Rethinking, an ecological system of man's health, disease, aging and death, journal of school health in Laurna Rubinson ibid. p. 39

confused. Disease is largely a scientific, medical and technical territory that encompasses what is known about biologic impairment. It has been explored with diligence and its many variations weighed and measured, and their labels are considered more or less universal. Illness is the territory in which social judgment defines that deviating for which the physician and other health practitioners are considered the official remedial agents. It includes biologic deviance but encompasses a wide range of human behavior also judged to be deviant illness is culturally defined."[88]

The outstanding feature of health is that is it is a quality and therefore cannot be weighed and measured. Heath is not a single crudity or condition. These are levels of health that can be distinguished one from the other, but it is easier to observe the differences than to be defining health itself. That it exists seem certain, but getting a firm hold on it is virtually impossible. In fact, the health territory has no independent existence at all. It is a state of mind, a proportion of our beliefs about the nature and perfectibility of humans and our values judgments about what constitutes a good person in a good society[89].

Over the years, health education has been defined and conceived of in various ways. It has been called a " quasi-academic area" an emerging discipline, which has grown from infancy to adolescence and a vital component of health and medical programs which utilize educational processes to disease preventive, curative, rehabilitation and health- promotive ends. In 1977, a report on current status and needs for health educations was prepared with the support of Bureau of Health Education in the United States. The rational for this report was as follows: Health Education as a profession and as a field of endeavor is fragmented among a variety of organizations and disciplines. This fragmentation is accompanied by a

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[87] Webster in Laurna Rubinson ibid.p.40
[88] Carlyon W. H. coming back from utopia, health education in Laurna Rubinson ibid

panorama of nations about what health education is and about what competencies is needed adequate performance. This fragmentation and lack of definition often result results in lack of recognition, and priority for the professional health educator.

In 1976, a conference on professional preparation was held in Towson Maryland. One focus of this conference was a discussion of the question what is health education? It was not the purpose of the Towson conference to define health education, but participants accepted the following statements concerning health education: Health education is a professional field and an academic discipline eclectic in nature for its scientific base; health education strategies provide needed approaches to bridging the gap between scientific discovery and its application for every day healthful. Purposes; Health education is an integral part of the school curriculum at all levels and an integral component of community-based health programs; health education contributes in the total education of individual and strategies are based on and improved through basic and applied research; Health education is most appropriately engaged in by the professional prepared health education; Health education facilitates the primary prevention of health programs[90].

Mico and Ross stated the beliefs of many professionals in the field "Health education is an educationally-oriented process; Its target is the individual, even when conducted in community or mass media settings; it focuses on closing the gap between that which is know to be good for health and that which is actually being practiced by the individual; and it is concerned with the behavior of the individual and forces of needs; values, maturation's and perceptions that influence those behaviors."[91].

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[89] ibid
[90] 1976 conference on professional preparation held in Towson Marryland in Laurna Rubinson p 41

Health education was defining by the working group on the Role declaration Project as a "process based upon a scientific principles, which employs planned learn opportunities to enable individuals acting separately or collectively to make and act upon informed decisions about things affecting their health. Encompassed in this definition are efforts directed toward assisting people to achieve an optimal level of health, to prevent disease and debilitating conditions from occurring, and to minimize the impact of such disease and conditions on individuals who have been affected. The focus point for health education activates are individuals and individuals acting collectively in groups and organization. Through education, health education specialists work to enhance those factors that predispose, enable and reinforce healthy behavior. As such, is health education a unique and distinct discipline, different from nursing or medicine through it its purpose and its method?

Recently two fields have emerged that bear close resemblance to health education as it was being defined and described. One of these multi disciplinary fields is called behavioral medicine, the field is defined as being concerned with the development of behavioral science, knowledge and techniques relevant to the understanding of physical health and illness and the application of this knowledge and these techniques prevention, diagnoses, treatment and rehabilitation.[92]

Dwore et.al discourses in a scholarly paper another development germane to health education, the emergence of behavioral health. This is an interdisciplinary field dedicated to promoting philosophy of health that stresses individual responsibility in the application of behavioral and biomedical science knowledge and techniques to the maintenance of health and the prevention of illness and dysfunction by variety of self- Initiated individual or shared

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[91] Mico et.al, Health education and behavioral science in Laurna Rubinson et.al ibid.
[92] ibid. p.42

activities. The purpose of behavioral health is promoting health among currently health people. The behavioral scenes are generally considered to include such are psychology, sociology, anthropology, economics, political science, and geography. These disciplines are concerned with individual and collective behavior of people in various situations. The extent to which they focus on health varies more than discipline to discipline. Obviously health education is rather significantly improved in health and behavioral medicine"[93] Matarazzo et al suggest:

> "The behavioral sciences and health education have many common means and ends, strengths and weakness. Both are oriental toward studying human behavior and improving the quality of life for the individual, family and society through teaching, research and service...both are seeking to increase their scientific knowledge base and hence improve the potential of the services they provide...neither are, nor any are, has the monopoly over the study of human behavior, including the factors and processes involving in health promotion i.e. decision making, learning theory, behavior modification, human values or growth and development. Instead differences largely are based on degrees of emphasis and issues of content. Traditionally the behavioral services have been more academic that applied. Health education developed somewhat untraditionally with problem sowing and application proceeding theory"[94].

Dwore et.al again suggest three ways in which behavioral science and health education may relates to one another, including: to continue as at present with little formal

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[93] Dwore et.al in Laurna Rubinson ibid
[94] ibid

articulation; to compete with each other for large resource allocation through claiming primary in common areas, and to interact with each other for multi discipline any collaboration in which cross-fertilization of ideas is stimulated[11] Health education programs can help participants prevent disease, enhance health and manage chronic illness as well as help improve the well-being of organizations and communities"[95].

6.1 The Setting For Health Education

At 1978 Bethesda Conference entitled commonalties and differences in the preparation and practice of health education. Helen Cleary suggested three possible classifications for health educators perform both teaching and planning functions each has major responsibility for one of two functions: those who teach in schools, colleges, medicine care institutions or comminuting settings or those who plan, organize, coordinate and evaluate health education programs, or comminuting settings.

The second classification offered was by the type of institution in which the heath educator works. The classification of non-medical care institution, versus medical care institution is an example of this scheme. Cleary suggests that tutors perform disease education and health educations in non-medical institutions perform primarily health education.

A third classification proposed by Cleary was by professional identity. In this regard, committee on professional preparation and practice identified three types of health education: those who teach health education in schools; those who plan, coordinate, and evaluate health

[95] ibid p. 43

education programs in schools and other settings; those with a professional identity other than health educator who perform health education. Cleary suggests that the distinction by professional identity may be the most useful.[96] Talking about health educators we are referring to professionals who identify health or disease education as their major responsibility in discussing the community, patient and social settings in which health education takes place. If you examine the locus of each of these three elements, you will note that community is an abstraction, Parents refers to school as identifiable place of designated land of health educators. The concepts of community would include the school or university as a community: the work places as a community the home as a community, the neighborhood, the state, the nation. The perimeters of the setting in which a health education program takes place delimits the community e.g. hospital based, school based and home based. In referring to sometimes subtle, sometimes resounding differences of opinion regarding health education, its substance and goals between public health educators and school health educators Sliepcevich warns " we cannot let territorial imperatives implied in titles interfere with our common goal of education for health"[97]. WHO may also see health educators in other settings by noting that-

> "Role, function and setting are interrelated and interdependent. As any one of these changes, so will the other two...in reality that the orientation of social structure and the settings determine the boundaries of health educators' role and function"[98].

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[96] Helen Cleary in 1978 Bethesda Conference entitled commonalities and differences in the preparation and practice of health education in Laurna Rubinson et.al ibid
[97] Sliepcevich in Laurna Rubinson et.al p 44
[98] ibid

During the first half of the ninetieth century education established itself as a profession. There were an increasing number of colleges, known as normal schools that specialized in the training of teachers. This formal training is pedagogy demonstrated that classroom instructors were in need of special skills not found among the general population, even among the learned within the population. Soon the specialized training in teacher preparation became even more specialized as programs evolved according to content areas. People were not only studying to become teachers but also to become science teachers, English teachers, history teachers, and health and physical education teachers. This professionalism is important because it helped enhance the role of the teacher and demonstrate the value of instruction by specialist in each area of study.

Health education began to grow because of leaders who were able to envision the positive outcomes for society. There were people who popularized heath education through personal contact and the written word; William Alcott was such a person. He popularized his ideas through a series of essays and books published between 1829 and 1850."[99]

6.2 Missions and Goals of Health Education

Perhaps the first and most basic questions on the philosophy of profession are: what is this discipline for? What is its body of knowledge for? On this topic Burt says, "Professionalism begins with a group of people bound together by common purpose or purposes and operating with recognizable boundaries-boundaries known to those within and outside the group". Has the health education as a profession identified its base mission? Are health educators bound together by common purpose(s)? Are we operating within clearly delineate boundaries?

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[99] ibid p 45

Some would respond alternatively to all three of these questions, social physical and emotional among population groups. They would also say that the use and value of health education is that it helps the individual and society in general to achieve, restore and maintain health. Other health educators would unequivocally say "No" in response to each question and also: How many times will it take carefully selected groups to go to the well and return without water before someone discover that a pitcher without a bottom, without a base should be replaced by one that has such an essential, if they expected to come back with the water.

The health educators express frustration with what they call "the intensive superficiality" in health education as it now exists. Others suggest that although we do not have our act together yet as a profession, we are making some progress and that perhaps what we need to do is to go back and explore the values of the filed before we can identify goals. At this point, the examination of efforts or health education that focuses on identifying its goals and parameters become imperative. At the 1978, Bethesda Conference on Health Education, participants was asked to respond to the question "what do you perceive as the goals of health education.

After an initial generation of goal statements participants realized that the statements they had come up with were quite diverse in terms of scope and content. They decided therefore to identify and an overall or umbrella goal separately and to place more specific goal statements into a sub goal or supporting goal category. These goals, as viewed by the workshop participant's essence set the parameters of the field. The goal statements listed below represent as a synthesis of views expressed in the various discussion groups.

The goal of health education is to maintain, promote, and improve individual and community health educational process.

Background: The discussants agreed that there are certain fundamental elements that should be incorporate into a general goal for the profession. The over goal stated above sets forth the important link between health and education, that is a characteristic of the profession. It points out that the impact of health education is broader than that of disease prevention or therapeutic educational intervention. It covers educational activities relating to maintenance, promotion and improvement of health. This goal therefore suggests a wide continuum between health disease, spanning both prevention and treatment. Moreover, it illustrates the dual concern for affecting health on both an individual and community level.

Sub goal. 1: to foster or facilitate individual community responsibility for the prevention of disease and the management of optimum health status.

Background: one of the issues raised by the discussants defined the difference between the ultimate responsibility for disease prevention and health maintenance and the responsibility of the profession to facilitate individual and community acceptance of this ultimate responsibility. Although that they concurred that health educators help define behaviors that are positive or negative to health status, then prime responsibility is to facilitate health behavior change processes that have already begun within the society. In providing activities that motivate and stimulate people toward health-related behavior, heath educators assist provider and advance wellness maintenance. In addition to define responsibility for disease prevention and health maintenance, this sub goal also points out the continuum implied in the meaning of health from disease to optimum heath status.

Sub goal 2 is to facilitate opportunities among individuals and communities to make informed decisions and intelligent choices regarding health and health behavior.

Background: The general consensus among participants that health education should provide a milieu in which change is possible. It should make the range of choices and the consequences of each choice apparent to the target population. The participants indicated that health education as much as possible should involve facilitation coercion or manipulation regarding health and health behavior.

Sub goal 3 is to effectively stimulate community interest in health resulting in the development of consumerism, participation, conservation, and prevention of what benefit to the individual ... community interest in health?

Background: the participants viewed health for any individual as being to a large extent a result of community decision. They agreed that health education therefore must be specifically concerned with the role of the community in the maintenance, promotion and improvement of health. Reflecting the central importance of this issue, they concluded that community interest leads to or depends on informed decisions and increased acceptance of responsibilities for health.

This compilation of goals represents that work of various health education professionals who came together for a three-day period to consider this discipline of which they were members. This is indeed one useful way to identify the goals of profession. Philosophers have always emphasized the need for bringing together or synthesizing

experiences, ideas and beliefs. This workshop provided a type of synthesizing experience for participants.

It brought together those who identify themselves as public health educators, school health educators and patient educators. It offered participants an opportunity to explore center of belief and promoted that recognition of relationships between and within the experiences of health educators who function in various settings.

However, the viewpoint of the participants is of equal importance in attempting to identify the goals or values of a field. What do participants in health education encounters get out of experience? What do participants want to get out of health education encounters? Answers to these questions will particularly provide us with the information we need to decide if health education has a place in schools community health, agencies worksites and health care institutions; for that matter, if health education even has a place in American eye.

These are crucial questions when determining goals. Before you discount this last statement as pure heresy remembers that the philosophic process is impossible when emotional movement is strong or when a close-door attitude exists. As Davis and Miller stated: " personal interest can be so emphasized and insisted upon that almost everything else seems unimportant, perspective is lost, sound thinking becomes difficult, even impossible" You must be careful not to become a slave to an idea; rather control and modify ideas and beliefs as you gather truth. In similar way, by sidestepping the difficulty and searching for security, the philosophic process is thwarted. As health educators we need to guard against being satisfied with lists of words that represent values that reflect credit on the profession and its members.

In order to clarify these thoughts on the value dewed and perceived by participants in health education, let us analyze identified earlier in sub goal 1 to foster or facilitate individual or community responsibility for the prevention of disease and management of optimum health status.

Is it possible that some people just value things more than health and that moneymaking or love making is more important, or that comfort, convenience, and immediate gratification are more important than the long term concern of good health? Should we be trying to make individuals assume ultimate responsibility for their health? If as professionals we truly believe in freedom, would not we also in "informal refusal"? This question is not we but rather social we are providing activities that motivate people toward adopting health behaviors? Is this what participants' want?

Sub goal 2 is to facilitate opportunities among individuals and communities to make informed decisions or intelligent choices regarding health and health behavior.

Do participants want to know about the importance of good health of eating breakfast each day, or exercising three times a week, or practicing self-hypnosis daily? Or do participants want to know how to start and maintain a regime of exercising self-hypnosis, and eating breakfast?

Is it knowledge the participants want and value? Do they merely want information they feel that they can use? Or do they want more? Do participants want to be able to make informed choices about health and health behavior?

Sub goal 3. To effectively stimulate community interest in health resulting in the development of consumerism participation, conservation and prevention of what benefit to the individual ...community interest in health? Do individuals that they want to profession like health education to help them participate as active health consumers? Do all people, or even most people, value conservation?"[100]

John Burt emphasizes the necessity of a profession identifying with and understanding the "want" of its constituency. He explains it this way:

> "To develop a successful enterprise it is necessary to market a product or service for which ...is a consumer. To become a legitimate enterprise the product or service must be reliable and worthwhile. To become both successful and legitimate, an enterprise must acquaint the consumer with product or service that is worthwhile and in turn, the consumer must try it and like it. "Health education could become a very successful and legitimate enterprise. The market is right. In fact, our time has come" is an echo often heard. But somehow the price of our stock has failed to exhibit a spurt, a condition exacerbated by the rapid growth of related stocks. Some one ought to research both the market and the service. Indeed, may be all health educators ought to research the matter".[101]

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[100] ibid p 46
[101] John Burt in Laurna Rubin son et.al ibid p. 48

6.3 Health Investment and Purpose of Health Care

Humankind would not die out if formal health care systems did not exist; they are not biologically necessary for the survival of the species. Malaysia's estimated per capita health expenditures in 1990 according to World Health Organization were about US$67. Malaysia spends about 3 percent of GDP on health services, considerably less than the health expenditure of other developing countries. These low expenditures are attributed to the emphasis on creating a rural health infrastructure and implementing health promotion and preventive health care programs. The budget of the Ministry of Health (MOH) has increased in real terms, but the allocation remains more or less constant at about 5 percent of the national budget and 2.5 percent of GDP. The majority of health care and health related facilities belong to the public sector and are funded through general taxation from public revenues. In fact, the government provide most of the funding for health services, with the Malaysia ministry of health providing most of that; users fees collected in government hospitals contribute only about 5 percent of the total (MOH) expenditure"[102]

In fact, the 7 % of Gross domestic Product (GDP) spent on health care in UK is not the total health system. On recent analysis of United Kingdom health spending, the Executive North West stated that only about half of all UN health care is accounted for, through the National Health Service. Much health care is undertaken in an unplaced and unsupported way outside the statutory health care system. The total cost of NHS spending in 1996 was approximately $42 billion, but the value of informal health care outside the NHS is over

[102] Elizabeth Perkins (edited) Evidence based health promotion, publisher, John willy, West Sussex,. England, 1999,p. 126.

accounted for by care, the balance being accounted for in large part by self-help, self-medication and alterative therapies.

It is salutary to reflect that the UK, in the eighteen century, lay perspective on medical care as an integral part of both medicine and hospitals. Non-qualified persons had from inception dominated the clinical organization of hospitals, including patient admission and it was not until 1880s that consultants firmly gained control of medical appointments and teachings. A key determinant of this was that, in the domestic world, which at that time remained the principal locus for healing, popular remedies, and therapeutic systems could easily march the effectiveness of hospital-based clinical medical practice. The unifying goal of the NHS is to improve the health for all of the population."[103]

But in this task Smee et al, argued that evidence-based health investment needs to pay particular attention to increasing allocative efficiency in National Health Service. Smee et al defines technical efficiency as doing things right. The suggestion is that even if the NHS is achieving good health outcomes from health care, there is still a need to review whether the same investment made elsewhere could bring increased benefit to population health"[104] .

The World Bank has raised similar concerns at a global level. In reviewing the relationship between national health expenditures, and population health outcomes in 1993, World Bank stated thus: "at any level of population income and education, higher spending could yield better health, all else being equal. The fact that international health sector investment is unrelated to population health outcomes is not perhaps surprising, prompting

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[103] Walter W Wieners (edited)Global Health care markets. A comprehensive guide to regions, trends and opportunities shaping the international health area, publisher, Jossey Bass, San Francisco, USA 2001 pp.274-275

[104] ibid

the U.S. surgeon General to list in his May address the "general causes of premature death and disability as due to inadequate access to medical care; genetic problem; environmental, behavioral lifestyle factor." [105]

Despite this and similar evidence on the poor population health outcomes in the health sector, many governments still experience huge spending around the world. The NHS activity is overwhelming dedicated to the treatment and care of prevalent disease in individuals, resources are focused only on the small percentage of the population who are ill at any one time, to the exclusion of those who certainly will be ill if preventive action is not taken through the investment of those resources, elsewhere the first purpose of developing a body knowledge about evidence- based health promotion must be to assist health care at national level. Health authorities and trusts spend of 1% in the UK G D P on health, according to annual reports would not look any difference were all their patients to have died It sometimes seems that whilst everyone knows what they are busy about in the health care system, ironically, the most frequently ask question of health promotion by all these agencies is. Does it improve health.? But planned health promotion interventions enjoy budgets of less than 1% of the UK total spending on health. With such level of investment, it is inconceivable that they could be anything other than largely irrelevant to population health except perhaps on a political and symbiotic level. Yet researchers undertaking so called effective reviews employed by the Health authority, York University and the international Union of Health promotion and education (UHPE) earnestly searching for evidence of effectiveness. Solely within that 1% as if it might make a difference.[106].

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[105] ibid
[106] ibid

It was suggested that only about 1% of the evidence already available one effective health care intervention has ever been used to show that research has very little impact at all on any public policy. Weiss argues that research rarely determines policy; rather it tends to be used to illuminate the consequence or support advocacy of decisions already made on the basis of custom and practice, values or interest. Health care requires scientific assessment of positive and negative effects of products, techniques, projects, models, institutions, or programs in health care. In this guise, it demand for appropriateness, efficiency, technical, allocation, clinical, social or institutional efficacy, effectiveness, equity, equality, productivity, sustainability or ethical behavior found in relation to a specific intervention in a specific context at a specific time.[107]

The International Society for Quality in health care (ISQ) launched a program called Agenda for leadership in programs for health. The initiative is structured as a foundation for health care organizations. This experts have noted that the key variables in health accreditation programs from country to country are driven by social structures, societal values and other cultural, political, economic and technological realities.[108]

Culture in particular has much to do with what is valued in health care because health is one of our most personal interests. For example people in developing countries may value access to potable water whereas people in developed countries value the availability of organ transplants. This is the expectation for standards and what is evaluated will vary among cultures, nations and regions. The purpose of health care may be acceptable if it focused on improving quality, reduce cost, increase efficiency strengthen public confidence, improving management, educate, rationalize payment schemes, and provide comparative data working.

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[107] Grain Mooney 2nd edition Economics, medicine and health care, publisher Harvester, wheat sheaf, Marryland, USA 1986, pps.29

This could be sustained through the accreditation of the following bodies: corporate governance and strategic direction; organization and management performance; human resources management; surveyor selection; development and deployment; financial and resource management. Certain performance measure for hospital and patient centered; access to care and continuity of care, patients and family rights, assessment of patients, care of patients, patients and family education.[109]

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[108] ibid 30
[109] ibid