ENHANCING THE QUALITY OF LIFE THROUGH HEALTH EDUCATION

Health Education: Enabler for a Higher Quality of Life

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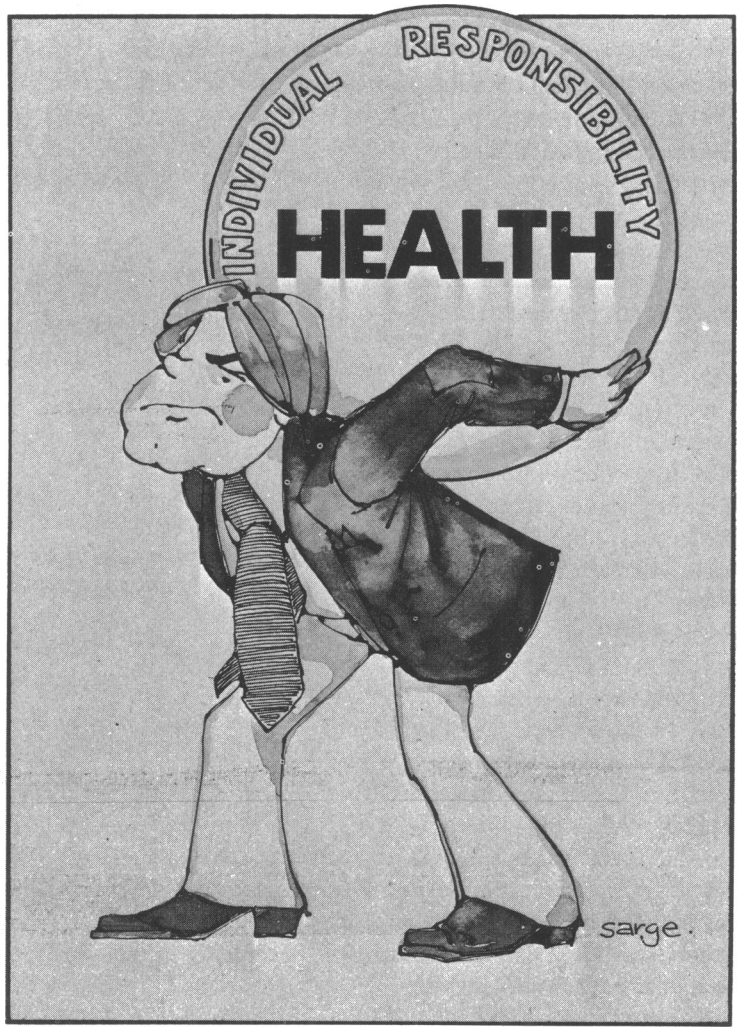
Quality of life appears destined to become one of the most talked about yet least understood topics of the seventies. Elusive to define and difficult to measure, quality of life nevertheless pervades more and more of our thinking. This series of papers will neither resolve the many issues surrounding quality of life, nor give a simple definition. The intent of the series instead is to shatter the mystique surrounding quality of life by reducing the concept to more concrete terms and stimulate thought about its relationship to the theory and practice of health education.

The six articles which follow are intended to serve as an introduction to the subject. Considerably more research, analysis, and introspection will have to be done before definitive statements can be made. Unlike previous timid and often cursory glances into the quality of life, this series takes a rather bold and unabashed approach—looking quality of life squarely in the eyes insofar as it affects education. There is little doubt that health education has an effect on the quality of life. It may come as a suprise to some as they read these articles to learn that the reverse is also happening. A growing concern for quality of life is having a marked effect on health education. The series looks at these effects and raises some questions for health educators to ponder in considering their own attitudes and expectations toward this topic.

While the emphasis of this series is on health education, many of the concepts and conclusions



drawn by the authors are felt to apply to other health disciplines. The educational process has some unique, but by no means exclusive, contributions to make toward improving the quality of life. It is the hope of all the contributors that the material presented will be provocative for those in many health fields besides health education.

The series provides a range of views as a way of demonstrating the dynamic nature of the topic and to offer a broad perspective to a complex subject. My introductory article identifies a few of the determinants found in quality living and suggests why the educational process is a relevant method for enhancing that quality. Four subsequent articles examine quality of life and health education in different settings. Elwood looks in depth at the diminishing quality experienced by the aged. Russell takes the now familiar topic of deteriorating environmental quality but considers it in a new light as a challenge for the health educator. McKay reminds us that quality mental health can open the way to a quality life. Cervantes, in clear forceful terms, tells us that quality of life for Chicanos cannot be achieved through an Anglo definition. And finally, D'Onofrio discusses how a professional health education organization can do its part to bring quality of life into the mainstream of consciousness and sidecurrent of action.

No author claims to be an expert in the quality of life—either before or after the series. But we share one point in common: we all are trying to examine our own practice of health education in light of a national interest in quality of life and trying to modify that practice in ways that will enhance quality. If there is an overall message to the series, it is perhaps that other health educators or others working in the health education process should consider doing the same thing.

Shattering the Mystique

The genesis for the series was a successful 2-day conference on health education and the quality of life. The 1971 annual meeting of the Society for Public Health Education (SOPHE) was devoted to this theme. More than a few skeptics questioned such a topic for a professional society meeting, saying it was too vague and nebulous. They were wrong. As the sessions unfolded, participants demonstrated that quality of life could be discussed not merely in token terms and glib generalities, but in reasonably concrete terms having meaning for practicing health educators.

Held October 9–10 in conjunction with the annual American Public Health Association meeting, the SOPHE conferences in Minneapolis, Minn., broadcast a clear message to one of the largest audiences in the organization's history. The message in Minneapolis was simply this: "Health education's effect on the quality of life can be broadened through political and social interventions as well as through the educational process, through interaction with consumers of all backgrounds—including labor and political office holders—and through a deeper understanding and sensitivity to the determinants of the quality of life"(*1*).

Four speakers at the conference—a clinical psychologist, an environmentalist, a health administrator, and an international consultant—demonstrated, along with practicing health educators, that quality of life could be more than a theoretical concept, more than a platitude, and more than a convenient phrase to camouflage tinkering with the status quo.

Perhaps for the first time health educators as a group realized the full impact of this concept on their own efforts.

A New Image

SOPHE's 1971 annual meeting documented the relevance quality of life has to the health education profession. The conference, as most meetings do, raised more questions than it answered. Knowing that the educational process does influence quality of life, how can the process be improved to maximize quality? How does one really define quality for different people in different places? How does a knowledge of the quality of life affect the daily practice of health education?

To begin to answer some of these questions, a series of articles was contemplated—a series to be written not by theoreticians, but by people who use the educational process daily. The authors were drawn from a variety of job and geographic settings. Each was asked to examine the quality of life concept in terms of his own experience.

The series does not represent a neat, tidy entity. The editor allowed the authors considerable leeway. The result is one further step toward an understanding of how a concern for quality of life can affect what health educators do. What emerges from the papers is a clarification, not a resolution, of the quality of life concept and, perhaps more importantly, suggestions on how the educational process can be used to improve the quality of life in a variety of situations.

Health educators are generally aware that what they do has an effect on the quality of life. A woman educated about the importance of prenatal care or a diabetic educated to change his style of living to cope with his condition has an improved quality of life. But there is considerable doubt whether the health education profession as a whole understands the many dimensions of the quality of life and takes them into account in daily practice.

While there is little doubt that health education has an effect on the quality of life, it is less clear what effect a concern for quality of life will have on health education. That it already is having an effect is indisputable. At least four trends are apparent now (*1*):

1. A continuing shift in public interest from a focus on the prevention of premature death, excessive morbidity, and disabling injury to an ascending concern for the total quality of human existence, for the maximum development of human potential, and for the development of environments in which such human capacities may flourish;
2. An increasing public demand, not simply for the delivery of such environments and life-saving circumstances, but for participation in the framing of the end-state and instrumental decisions necessary to their delivery;
3. A shift in institutional behavior from a commitment to "process" to a focus on "purpose;"
4. A trend toward the practice of public health in a variety of institutional settings, rather than in agencies that carry "public health" in their official titles.

There may have been a time when quality of life could be discussed as a fad—a replacement for those whose ecology buttons had become tarnished through lack of use and other true believers. Even if this was the case at one time,

it is no longer. Concern for quality of life runs deep and already has begun to influence policy decisions, not only in health but in all areas that affect people's lives. The question is no longer whether or not health educators should react, but how?

My paper serves both as an introduction to the concept and to the papers that follow. It is not a summary; the papers speak for themselves. I propose to discuss the general concept of quality of life in light of several major themes which I, as the editor, found emerging from the other papers.

Quality: A Personal Determination

There is overconcern with the definition of quality of life. It is as if people thought, once it was defined, they would know how then to deal with it. I claim there is no "one" definition for the quality of life. There are, in fact, many qualities of life. What should be paramount to health education is not the isolation of "a" quality of life, but a determination of quality of life in terms of the people being served, the client population. To the aged person living in the midst of services but unable to reap their benefits, quality may be simply mobility. But the kind of mobility he seeks is not the same that the young deem so essential.

The transportation supervisor of a local neighborhood health center had to explain to his confused drivers why a car was parked at many of the homes to which they had been summoned for transportation. The drivers soon learned that many of the aged could not drive and had no one to drive them, even though they owned a car. Mere possession of a car failed to improve quality of life for these people.

Traditional definitions of a quality of life, however, have been couched in material terms. Look, for example, at how one State views its "good life" (*2*):

> The sum of the "good life" in Minnesota is very good indeed! In every category . . . Minnesota life demonstrates a vitality and progressiveness that can serve as a model for most of the rest of the the nation. The individual can find maximum opportunity for growth in Minnesota. He is accepted readily, regardless of race, color or creed. He has access to one of the best educational systems in the nation, and to health and welfare facilities unexcelled in the 50 States. The democratic processes are enthusiastically pursued and invite his participation. He can make a good living, and expect his income to grow steadily, while enjoying family life in a beautiful, well-maintained community. The business firm locating in Minnesota will find a like compatibility—amid a surging economy and one of the most productive, reliable labor forces in the country. Measured against the criteria used, or any other, the "Quality of Life" in Minnesota is indeed a life of quality.

Quality of life, to some extent, does imply material possessions, access to education and health care, and security in job and home community. The question that continues to perplex many people is, to what extent? The debate and study will continue. Rating charts, cost-benefit analyses, and other techniques will be used in an attempt to quantify quality. While the health educator should be aware of this effort and follow its development, his unique contribution need not be delayed until all the results are in.

It is already becoming increasingly clear that quality of life will never be a thoroughly quantitative phenomenon, but will always be, to a certain extent, a function of a person's expectations. Wall Street Journal columnist Richard D. James, in assessing the many ways to measure the quality of life, concluded that "All of this suggests that quality of life is related, at least partly, to what people believe they ought to have and believe it's possible to have" (*3*).

While the system analysts, economists, and engineers tinker with the quantitative side of the quality of life, the educational process can be used to deal effectively with its qualitative side. The health educator is certainly no stranger to the areas of perceived and actual expectations.

Quality of life is impossible to define only if the person is seeking the same definition for all people. If a person cannot define quality of life in terms of things he has, he can usually define it in terms of things he does not have. We often feel quality of life most often after it is gone. We know it exists, too, through its variations. Archibald O. Haller, in the proceedings of a workshop on quality of rural living, concluded (*4*):

> As you can see, I think the main problem of rural society is the same as the main problem of urban society. It is concerned with variations in the quality of living. It is concerned with unequal access to the experiences that constitute the good life, and with the rights, goods, and services that are prerequisite to those experiences.

Style of Life vs. Quality of Life

Quality of life and style of life are not the same. Dr. John Brantner, in discussing the psychological implications of the quality of life, cau-

tions not to confuse the two. To do so could result in imposing certain styles of life and possibly reducing the quality of life. In his words, "public health education must be careful lest it set up impossible and false expectations. You must teach people broadly where the quality of life does lie. You must teach people to examine their own lives, and teach them to decide" (*1a*).

Most people, even those in prison, have discretionary time—a period of the day when they can do what they please. What a person does with his discretionary time tells us about his style of life. How much discretionary time he has tells us about the quality of life. These are not absolutes, however, only indicators. More time for leisure does not necessarily mean higher quality of life. For example, it is generally true that the rich have more leisure time than the poor. Because the poor must work longer to earn their living, their leisure may actually be more valuable since they have less of it (*3*).

The role of a health educator is not to dictate the way life is to be lived; way of life is clearly the prerogative of the individual. The educational process can, however, be used to inform people of how their choice of life style affects them, their families, and others around them. The notion that life can be lived in a variety of ways seems common enough, but there is some question as to how well this idea has been internalized.

If there is no one quality of life, but innumerable qualities of life, and if it is not to be confused with life style, the knotty question arises as to how principles can be derived, policy set, and action initiated. How can a health educator act if people disagree on the course of action? Like most complex topics about which people disagree, there is common ground. Even in this beginning treatise on quality of life, several common themes emerge. At least three common threads can be noted:

1. Quality of life implies choice—knowledge of all the available options, freedom to choose any option, and an understanding of the effects once a choice has been made;
2. Quality of life implies increased individual responsibility for health;
3. Quality of life implies the development of new skills and roles for health educators as well as the full use of existing strategies.

In the remainder of this paper I discuss these themes in detail and draw conclusions, tentative though they are, for the health education field.

A Question of Options

Quality of life is related to choice. If a person has options in his job, where he lives, and what he does with his spare time—he has, to some extent, quality in his life. That quality is diminished, however, if he does not know about all his options or if something limits the choices he has.

As the following articles reveal—the aged, the Chicanos, those with mental health problems, and those living in a deteriorating environment—all have constraints to the quality of their lives. Their choices are limited.

I suggest that a health program with an objective of giving a Chicano a choice in his living environment will yield different and perhaps better results than one with an objective of improved health conditions. In one instance, a decision is made, perhaps in his best interests, but by someone else who already has closed several options; in the other instance, a decision is made by the person with someone helping him to use his full decision-making powers.

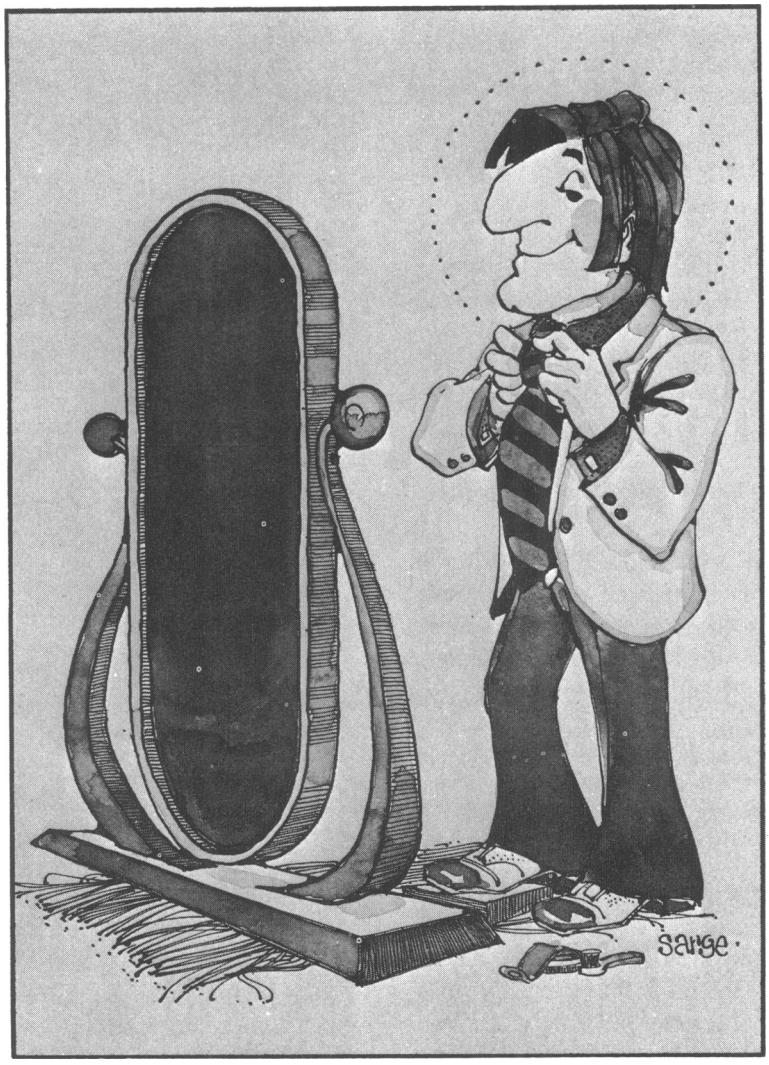
Most people know they have a choice and apply a given level of analysis before making their decision. What many people fail to realize is, that by making one choice, they close other options. There is a growing awareness of the fact that few, if any, interventions raise quality of life in all dimensions. What happens instead is that some factors are improved while others worsen. What is needed is more accurate forecasting so decisions can be made in light of balanced interests.

René Dubos is one of the best at reminding us that today's world cannot solve its problems with yesterday's programs (*5*):

> The greatest improvements in health during the past century have resulted from the continuous rise in our standards of living. But we may now be coming to the phase of diminishing returns. Our prosperity creates a new set of medical problems. Environmental pollution, excessive food intake, emotional deprivation, lack of physical exercise, the constant bombardment of unnatural stimuli, man's estrangement from natural biological rhythms—these are just some of the many consequences of urbanized and industrialized life that have direct or indirect pathological effects.

The health educator is in a pivotal position because it is knowledge that can make the difference between good and bad decisions, and the educational process is a prime means to communicate that knowledge.

Decision making with the benefit of knowing the trade-offs is already happening, most notably



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in environmental control. As Russell notes in a subsequent paper in this series, the relationship between environmental quality and quality of life is close indeed.

Having the courage to act in light of forecasts is still a novelty. Clay Meyers, Oregon's Secretary of State, recently announced the following courageous decision: "The majority of our people fear that any population increase would decrease their quality of life . . . that the tourist dollar is beginning to cost us too much in terms of pressure on our natural resources and recreation facilities." Meyers spoke before a joint convention of the National Newspaper Association and the Oregon Newspaper Publishers Association in Portland, Oreg., in 1972.

Improved decision making in health matters can be considerably aided by the health educator. The educational process can be used to accomplish the following: (*a*) educate people as to the choices they now have in terms of where to get health care, how it is to be paid, how they can improve their own health; (*b*) develop more choices for those who have limited options; (*c*) educate people about the negative as well as the positive impact each choice will have on his life; and (d) allow the person to make his own choices and assist him with meeting the consequences.

Personal Responsibility for Health

Another key theme emerging out of this beginning attempt to grapple with quality of life is the responsibility of the individual person for his health. Bringing the elderly to schools so they can learn about insurance benefits they have, but are not using, may be preferable to recrea-

tion programs as a way of improving their quality of life, as Elwood points out in his paper. Cervantes, likewise, asserts for self-reliance when he suggests that Chicano needs be determined by Chicanos, not by researchers biased by their own set of values.

Anne Somers has called the uninformed consumer a threat to any health care system (*6*):

> Given our national commitment to "comprehensive health services of high quality for every person," such individuals are not only endangering their own health but building up a formidable health care bill for the nation as a whole and are a threat to the future viability of any health care system. The commitment assumes rational individual responsibility for one's own health. Without this ingredient, the commitment cannot possibly be honored.

Increased personal responsibility for health is already a trend and no longer an idea. President Nixon, in launching the President's Committee on Health Education, stressed individual responsibility (*7*):

> At a time when it is essential for us to make the best possible use of our medical resources, it is all the more important that every American be fully aware of the measures he himself can take for his own well-being and personal health. Government, of course, has a part to play in preventive health maintenance, but the ultimate success of our efforts depends on the people themselves. . . .

Health maintenance, comprehensive health care, prevention, and the other emerging priorities of this era will not be achieved solely through administrative mandate or governmental fiat. The individual person needs to be educated not only about health problems but also about what he should reasonably expect from the health system. If peoples' expectations continue to rise, they will leap even farther ahead of the system's ability to respond. It is becoming increasingly clear that mass infusions of new health manpower and mass building programs will not improve health unless they are coupled with health education at a personal level. The individual person needs to be educated to accept the responsibility that goes along with increased freedom to make decisions concerning his health and the health of his family.

Allowing the client to be primarily his own change agent takes considerable honesty, if not downright courage, for those accustomed to being doer and helper. The role played by the health educator in this new context is more that of an enabler, allowing a person to be all he can be. It is important for the health educator to heed the advice of John Gardner, "We can reshape the environment to remove obstacles. We can stimulate and challenge, but in the last analysis, the individual must foster his own development" (*8*).

Consumer participation in health services is scarcely new. What is new is the way the consumer is participating. During the sixties, social remedies were dispensed in a manner ranging from the paternalistic to the humiliating (*9*). Casework was the predominant model. In handling a tenant's problem, for example, the caseworker would try to locate better housing or examine the adequacy of rent allowance in a welfare allotment. Appearing later on the scene were the community organizers. They might handle the problem somewhat differently by organizing a tenants' group to deal with the landlord, the sanitation department, and the health department.

A health educator concerned about the health of a tenant in terms of quality of life might handle the problem in yet another way. After first hearing about the tenant's problems with the landlord, he would inquire about other problems and perhaps find that there were even more serious ones than housing. He would then point out the relationships between these problems and suggest all the possible alternative actions the person might take to improve his situation. The goal—better housing, easier access to emergency health care, or whatever—would be determined by the client, not by the health educator.

This open-ended process has some obvious pitfalls and needs considerably more thought and analysis before it can be applied. Just the same, it does illustrate a different methodology and mind-set for the helper and places an additional burden on the person being helped.

The health educator locked into an agency narrow in its scope and suffering from tunnel vision would not be allowed sufficient leeway to perform in the role I have just sketched. If a health educator is to function as an enabler for health in its broadest sense, instead of as a narrowly conceived program emissary, a new perspective of the profession is needed.

Russell, in her paper, would have educators explain to a client how government works, who has the power, and with whom to communicate in order to be heard. Functioning in this way is a marked change from educating clients about acceptable health practices. Tutoring political in-

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tervention is certainly a new tactic for the health educator, but perhaps one that is needed if the person is to influence the quality of his own life.

New Strategies: Political Intervention

Politics and health education are far from being bedfellows. Health educators as a whole have only begun to make their timid entry into the political arena and the debut is long overdue. If social policy had little effect on the population's ability to maintain its health, perhaps health educators could afford to stay clear of politics.

Resolution of the many issues surrounding quality of life will not come about solely through quantitative means. While a person must be allowed to determine quality of life in his own way, the achievement of that quality is a matter of public policy.

Although other means have been tried to influence public policy, political intervention appears to be the major vehicle (*10*).

> People outside of government are often tempted to underestimate the complexities of public policy problems, and zealous systems analysts are not alone in their exaggerated confidence that, if only given a chance, they would quickly resolve the difficulties confounding government bureaucracies. . . . National needs are not defined by a central authority. Rather, in a somewhat pluralistic fashion, they emerge and vary within and between various issue publics or interest groups.

A health educator need not run for public office, although if given the chance, he should not shy away from opportunity to use the educational process at a policy level. What is required of health educators is a recognition of the importance of political intervention as well as other strategies in implementing health proposals. The brand of health education being defined by the President's Committee will not be achieved through program planning and communication strictly within the health establishment, however effective and professional it may be. A new coalition of educators, politicians, and others is needed.

The traditional skills of a health educator should not be diluted or sacrificed as he acquires a broadened perspective—they should be enhanced and expanded. The tasks health educators have been called upon to perform in the past will need to be performed even better in the future. Elwood and Cervantes, in describing the aged and Chicanos, point to attitude change as one means of improving their quality of life. Attitudes are part of the health educator's territory.

The sobering conclusion reached by a reading of these articles is that one of the groups most in need of education are the professionals themselves. Just as the health system has become so fragmented and unresponsive that people have begun to utter the phrase "heal thyself," perhaps the health educators should be uttering "educate thyself" to their professional peers.

Quality of life can be influenced not only by personal growth and possession of material belongings but also by what people do with their limited resources. The educational process can help people make better decisions within the range of choices open to them. Old strategies and new can be used to expand a person's range of choice. It can work two ways: (*a*) improved health can enable a person to achieve a higher quality of life and (*b*) conversely, a person allowed greater influence over his life can improve his mental and, in turn, his physical health. But to assume such changes will happen soon is unrealistic; to assume they will happen without a well-planned and implemented educational process is simplistic.

Health educators and the health education profession may well be at a crossroads. We can either bury our heads in our program guides and choose not to get excited by the current concern for quality of life, hoping it will go away so we can get back to the real world of educating, or we can examine our profession and our practice in light of these people vibrations.

This article and this series have only begun the inquiry into health education and the quality of life. The authors have raised many questions but not provided all the answers. This is the challenge we feel is squarely before the health education profession in this decade. What determinants of quality of life are most amenable to the educational approach? Can health education as a single profession, even in the form of a national coalition, create a meaningful impact or must there be a coalition between school educators, urban planners, politicians, and other heretofore unknown characters in order to influence policy? When does a person really have choice? How can we give more choices to the disadvantaged without reducing choices for others? How can a person be educated to accept partial responsibility for maintaining his own health?

These questions and others will be answered by those who have the interest and energy to do so. I hope that this series of papers will encourage some to do it sooner and better. Health education as a profession needs to adopt policy consistent with improvement in the quality of life. Schools of public health should consider changes in curriculum and field training that would stimulate students to recognize their impact on the quality of life. But most important of all, it is the individual health educator who needs to see how significant a role he can play in a society concerned more than ever in involvement and informed decision making—concepts health education has always stood for.

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