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A Case for Patient Empowerment Through Education

Gabrielle Hatton

The United States spends more money on healthcare than any other country in the world. It was reported that almost 18% of America's Gross Domestic Product was spent on healthcare in 2011, while the next highest country, Switzerland, spent only 11.5%.¹ This sizeable spending difference has resulted in neither increased longevity nor a higher quality of life.² I am sure this is not the first time you have heard these facts. While politicians, pharmaceutical companies, healthcare providers, lawyers, and insurance companies continue to place blame, pointing fingers at each other, I would like to suggest an alternative approach to this glaring problem. Patient empowerment through education should be one of the top strategies for effecting change in the health of our nation.

The United States has recently undergone an epidemiological shift. The decreasing incidence of acute problems such as chicken pox and tuberculosis over the past century can be attributed to effective public health initiatives, such as the development and administration of effective vaccines and improved sanitation and food safety standards. Currently, non-communicable diseases such as chronic respiratory disease, diabetes, cancer, and cardiovascular disease are much more significant in our society.³ In 2005, the Center for Disease Control and Prevention attributed 70% of deaths to non-communicable diseases and estimated that almost 50% of adults were living with at least one chronic disease.⁴ In 2010, the World Health Organization predicted a 15% worldwide increase in deaths due to non-communicable diseases by 2020.⁵ Most non-communicable diseases are causally linked with behaviors such as tobacco use, exercise activity, nutrition, and harmful alcohol use. These findings strongly suggest that our approach to healthcare should shift from treatment to prevention. Detection and treatment of non-communicable diseases are costly and often unsuccessful. If risk factors are addressed before a disease develops, there is no reason

to believe that overall quality of life, longevity, and health care affordability would not improve. Individuals must be educated to make the necessary lifestyle changes that will considerably reduce their chances of succumbing to a non-communicable disease.

Since 98% of children aged 16 and younger attend organized schools, the classroom provides an effective venue to reach the population. Furthermore, this age group is in the developmental phase in which they are most likely to develop critical health behaviors.^{6,7} Specific public health programs have been successful when using schools to reach their target audience. For example, students are now required to receive vaccinations, such as the Measles/Mumps/Rubella vaccine, prior to their first year of attending a traditional school. This has resulted in a noticeable reduction in targeted disease transmission. Health education focusing on tobacco use has also been introduced as a new requirement for students. This, in addition to other factors such as hazard labeling and tax adjustments, has resulted in a large decrease in tobacco use over the last fifty years.⁸ It is difficult to provide direct evidence for the effectiveness of these types of health programs individually, but they strongly correlate with important health improvements. Nevertheless, there have been few studies that have examined the cost-benefit ratio of health education programs in schools.

The studies that have been released focus on the cost-benefit ratio of specific educational programs for patients with a specific disease, initiated by medical professionals. A 1995 compilation of these education initiatives revealed that not a single study found their program to cost more money than it saved. Some studies even found the cost-benefit ratio to be as high as 1:12.⁹ If these results are not evidence enough for an education-based focus for reducing healthcare costs, they at least warrant further investigation.

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An important concept that must be noted when considering the effectiveness of the programs mentioned previously is that the patients' educators were highly trained. Likewise, in any potential health education program, the instructor should be qualified and the program should be delivered to the highest standards possible to ensure maximal effectiveness. When you think back to your own health education, what comes to mind? A gym teacher in a sweat suit? Sleeping in the back of a classroom instead of watching outdated films? These were my personal experiences. The current standards for primary and secondary school health education seem to be inadequate – and many students do not take the curriculum as seriously as they would with other educational subjects. The CDC provides broad guidelines for states to adopt their own health curricula. In New York, the New York State Education Department decides the specific topics their teachers are required to cover. The New York State Education Department does not work with the CDC or the Department of Health and Human Services to assemble an adequate curriculum. Schools then implement the recommended curriculum with a wide degree of freedom. Subjects such as reading, math, and science, are tested through statewide assessments. However, there are no standardized assessments that gauge a students' health knowledge and the CDC even recommends against using traditional exams for this subject matter.¹⁰

The goal of health education in schools is to provide students with the basic knowledge required to lead a healthy and safe lifestyle and to access health professionals when necessary. There is a direct correlation between school health education programs and health literacy later in life.⁷ However it is unacceptably common that schools do not comply with their health education requirements. In a startling 2003 report, Scott Stringer revealed that 75% of New York City school districts were in violation of at least one of the government mandates for health education and 63% of

school districts did not have sufficiently trained teachers in their health education departments.¹¹ It could be argued that these discrepancies are due to overall improper educational standards in the United States, but that is a topic that will not be discussed further. Regardless of the cause, if students are not getting the health education they are supposed to, they cannot truly be held accountable for their health behavior. Additionally, part of the health education problem may be attributed to the complex relationship between educators, students, and parents. This relationship should be examined and worked into health education programs to maximize chances for success.

The most cost-effective way of fixing any problem is to prevent the problem from occurring in the first place. Our society needs to shift away from merely treating diseases and move towards promoting the prevention of chronic illnesses that are now topping the morbidity and mortality charts. Only when Americans are properly educated on the

behavioral risks associated with the diseases plaguing society, will they be required to take responsibility for illness prevention and their overall well-being. Primary and secondary school programs appear to be the most cost-effective and improvable environments to provide the education that is associated with prevention. I urge all Americans and especially politicians, educators, and health professionals to put health education at the top of their list of priorities when addressing the effectiveness and cost of healthcare now and into the future.

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