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ABSTRACT

This issue is dedicated to exploring the nature of health promotion through the views and experiences of selected authors representing a variety of professional organizations, settings, programs, and activities within the profession. The articles are as follows: "Looking Back Over the Last Twenty Years" (Larry S. Chapman); "Views and Reflections of Health Promotion: Looking into the 21st Century" (Edward C. Framer); "The History and Future of Health Promotion and Wellness" (William Hettler); "Professional Preparation of Health Promotion Specialists: The Association of Worksite Health Promotion" (Jacqueline Hooper); "Health Education and Wellness in the 21st Century: Hospital Setting" (Karen Pedevilla); "The Evolution of a Profession: A Perspective from the Academic Setting" (John Sciacca); "Health Education in the 21st Century: An Outlook from the Academic Setting" (John Sciacca); "Health Promotion Specialist Preparation in the 21st Century: The Challenge for Institutions of Higher Education" (Roger Seehafer and Gerald Hyner); "The Importance of Prevention Research" (John Seffrin); and "The Evolution of Worksite Health Promotion: Where Have We Been and Where are We Going?" (Mark Wilson). (SM)

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The Health Education Monograph

Exploring the Nature of Health Promotion in the 21st Century

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Foreword

This issue of ***The Health Education Monograph Series*** is dedicated to exploring the nature of health promotion through the views and experiences of selected authors representing a variety of professional organizations, settings, programs, and activities within the profession. As such, it represents something of a departure from the traditional journal format with emphasis on empirical data generated from a specific research agenda and supported by a highly-referenced review of literature. In contrast, the contributing authors were asked to describe their personal experiences and share their opinions regarding the field of health promotion with a past, present, and future perspective. In other words, what was health promotion like when they first became aware of health promotion and became professionally involved in terms of a working definition as well as professional practice? Comparatively, what is health promotion today in terms of definition, major characteristics, achievements and limitations, and required professional skills and competencies? Finally, and perhaps most importantly, what are their expectations for the profession and the health promotion specialist at the advent of the 21st Century and beyond? The contributing authors were provided a framework they were encouraged to use in order to organize their thoughts and materials and, perhaps, to provide continuity of format for the articles that were submitted. The framework was suggestive in nature and intended to facilitate the writing of the manuscripts and not stifle the thoughts and personal contributions of any of the authors.

The articles which appear in this issue of ***The Health Education Monograph Series*** comprise the reflections, opinions, and predictions by a representative sample of long-practicing health promotion specialists from worksite and hospital-based programming, managed healthcare, the academic arena, private practice, and the professional organizations. The authors introduce to the newcomer in the field, and remind those of us that have been there, of the chaotic beginnings of health promotion as we know it today: a period devoid of any substantive content, theoretical framework or conceptual underpinning, professional identity or organization, basic skills and competencies, or even a commonly designated name. They provide an overview of where the field of health promotion is today and, although considerable diversity and confusion permeate even the present scene in terms of theory and practice, identify landmark examples which demonstrate how much progress has been made over the brief intervening years of the last two decades. They show that in terms of comparative disciplinary growth and development, events moved rapidly if not purposefully. Yet despite the confusion, trials, and tribulations which characterized the past and much of the present, the authors also point with a sense of optimism and enthusiasm to the future and its prospects for health promotion and the health promotion specialist. Although the answers to the questions and issues of the future rest in the hands of the health promotion specialist of the 21st Century, the Guest Editors of this issue of ***The Health Education Monograph Series*** hope that the readers will find their thinking critically challenged, the creativity of their efforts expanded, and the rewards for their efforts increased as a result of the work of our contributing authors.

We sincerely wish to thank all the authors who have worked so hard in the preparation of their manuscripts. Your interest, dedication and enthusiasm for this unique monograph issue is very much appreciated.

Sincerely,

Roger W. Seehafer, Ph.D., and Gerald C. Hyner, Ph.D.
Guest Editors, ***The Health Education Monograph Series***

Preface

On behalf of the National Executive Committee of Eta Sigma Gamma (ESG), I would like to express my sincere appreciation to the Guest Editors of this issue, Professors Roger Seehafer and Gerald Hyner, for the significant contribution they have made to the profession and Eta Sigma Gamma. They have gone above and beyond the call of duty in preparing and editing this timely, first-class monograph on health promotion. This is an excellent issue examining the concept, trends, evolution, and history of health promotion from different perspectives. They deserve our sincere thanks. Further, I would like to thank all of the authors who ultimately made this monograph possible. I genuinely appreciate their contributions to the **Health Education Monograph Series.**

I would like to thank Ms. Kathy Finley for her assistance in preparing the publication and Ms. Joyce Arthur for her technical assistance. Also the assistance of Mr. Jay Javed from our National ESG office is appreciated. Last, but not least, I would like to offer my appreciation to each and every member of the National Executive Committee who are very committed to supporting these monograph series.

Finally, thank you for sharing your comments with me regarding the past Monograph series. As always, I am eager to hear your criticisms, comments and suggestions regarding these publications. Your input is essential in improving the publication and ultimately serving our members and the profession in the most effective way. I do hope that you, as loyal members of this National Professional Health Education Honorary, check your college/university libraries and make sure they receive ***The Health Education Monograph Series***. If not, please request that they subscribe to these important publications by calling 1-800-715-2559. It is a privilege for me to serve the Eta Sigma Gamma members and our profession.

I look forward to hearing from you.

Mohammad R. Torabi, Ph.D., MPH, CHES
Editor, ***The Eta Sigma Gamma Monograph Series***

The Health Education Monograph Series

Volume 16, Number 3 1998

Looking Back Over The Last Twenty Years...

Larry S. Chapman MPH

At times it feels like change may be the only enduring human contribution to the Universe. Recounting the multiple dimensions of change that characterize the last twenty years of the health education/health promotion/wellness field is at once a humbling and daunting experience. As I contemplated my response to this request for perspective, I found myself reviewing the defining characteristics of this fledgling field that now appears to be coming of age. Twenty years ago I spent most of my time communicating the basic concepts of wellness rather than showing people how to carry it out in the context of populations. Now most of my time is spent working with population interventions. We are coming of age and we have encountered significant changes. My perspective as a preventionist and entrepreneur follows.

To me, characterizing the anatomy of change in our field first requires looking at some of the major aspects of our field/industry that define and set us apart from other disciplines. Each of these areas, in turn, is useful for revealing some of the often elusive markers or evidence of change. The areas that I would like to use to focus my comments are: changes in population needs, changes in use of technology, changes in expectations for impact, and changes in professional requirements.

Change in population needs: Twenty years ago the Surgeon General's Report on Health Promotion (U.S. Department of Health and Human Services, 1979) and Disease Prevention was first published. Our assessment of population needs then certainly seems naïve compared to the needs of present day populations. Add HIV/AIDS, increase in urban(and rural) violence, convenience living, "cocooning" lifestyles, disposable relationships, diminution of personal ethics and character, cultural diversification, the age wave, dual income families, generation X, Internet dating, genetic engineering, downsizing, "drill-down" information capability, on-line access, lawsuit lotteries, immediate gratification, consumer empowerment, (to name just a few of the underlying population and cultural changes) and you have a much different set of population needs to address. Our populations are more sophisticated, more demanding, less content to accept blindly what is provided to them, hold high expectations for tailoring and are more prone to question the authority of "health experts." Unfortunately, they also seem to express more schizophrenia about assuming responsibility for the consequences of their own choices: often unhappy or dissatisfied if we can't guarantee the "quick fix" that all of us have grown to expect from technology and science. They are a different group than we tried to serve twenty years ago. They've heard the basics and now want the "new" stuff. "Don't bore me with the fundamentals – I want something helpful to me now." Most often polite, but they are willing to quietly take their business elsewhere. No more generic programs for generic people.

Changes in the use of technology: Twenty years ago a sophisticated group presentation used colored overheads(whoa!); stress dots and a quick flipchart diagram. Today, we use computer projection devices with animation, sound, photographic images, video clips, and real time modifications. Learning is automated. Life revolves around computerization for an ever larger segment of the population. Multiple computers, internet websites, interactive learning, photovoice, multi-media integration, data warehousing, digital communication, e-mail, fax transmissions, relational databases, video-conferencing, broadbanding, inter-active voice response technology, inter-connectivity, are all part of our daily landscape. Welcome to the digital world! Is it changing the skill mix requirements for professionals in our field? Without a doubt! Are we becoming dependent on this technology? Probably. Is technology enhancing our effectiveness and our reach? Probably. Do we need to be careful that we don't lose the "human touch"? Absolutely! Can we use this new technology to individualize our interventions to match individual needs? Yes! Does this come without risks? No. Would I rather be any place else in time? Not on your life! Twenty years of technological advances have given us tools we did not even imagine in the late seventies.

Changes in expectations for impact: Another area where twenty years of changes are showing their age and effect is in the area of expectations for the impact of our programming effort. Twenty years ago, we were pleased if programs showed a positive return on our investment (i.e., a benefit/cost ratio greater than 1.0). Now we want programs to show significant health behavior effects with very high benefit to cost ratios (i.e., 6.0 to 12.0) at minimal investment cost without significant administrative hassles. At the same time we want these programs to reach all the hard to reach and to produce significant observable change while not offending anyone and producing high levels of satisfaction among participants. Do we expect the same from innovations in medicine or the other healing arts? Not likely! Can we deliver on these expectations for health education/health promotion/wellness? Maybe! Most likely with some careful design and execution strategies and a lot of serendipity. Is the level of expectation

about program impact going to moderate? Not likely! In a fast paced world with faster paced technology we will likely be expected to deliver results at the level of the sponsor's expectations. On the positive side, it may force us to examine our assumptions, methods, and intervention strategies in more intense and ultimately productive ways.

Changes in professional requirements: Looking back, the past often takes on a different perspective and reality than when we actually lived it. In reviewing the changes that have affected the health promotion/health education/ wellness field I am personally struck by the enormous change in the growth and sophistication of professional requirements for our field. With the expansion of scientific consensus on a wide variety of prevention issues, it has placed a substantial burden of technical knowledge on health education/health promotion/wellness professionals. This growth of technical knowledge, unfortunately, never seems to keep pace with the change affecting populations and sub-populations that we target for intervention. In addition, the growth of worksite-based programming and managed care have created very unique professional demands and requirements. We now require that professionals evidence a fair depth of knowledge about the realities and peculiarities of working organizations and populations as well as the dynamics of managed care. The CHES certification has helped to meet this emerging professional requirement. Most of these types of environments are much less stable than their counter-parts of twenty years ago. Mergers, divestitures, acquisitions, and equity restructuring are organizational changes that have profound cultural impacts on employer and managed care organizations. Managed competition, as a strategy for stabilizing health costs, with its intentional movement of employees from health plan to health plan, places greater importance on preventive interventions with short term effects on utilization and cost. The growth of community-wide prevention initiatives also requires newer professional skills and requirements in coalition building and cultivation of stakeholders/partnerships. Meanwhile, professionals in managed care are faced with the program delivery and information demands of Health Plan Employer Data Information Set(HEDIS) requirements, a set of indicators for evaluating the quality and performance of managed care vendors developed by the National Committee on Quality Assurance. Running through all settings and roles is an increased level of requirements for evaluation and research methodology. Answering the primary concerns of a variety of stakeholders usually requires a growing evaluative skill base. Measurement strategies and techniques for health status, health behavior, and economic impacts are also part of these newer requirements for professionals. Another skill set that is becoming more of a requirement is the ability to diagnose and actively intervene in organizational and community culture. Building healthy organizations and healthy cultures will likely create expanded professional requirements for all of us in the years ahead.

In summary, I believe that the health education/health promotion/wellness professional of today has to have a broader knowledge base, a broader skill mix, a more extensive understanding of a variety of cultures and how they change, increased skills at adapting interventions to individuals and cultures and the ability to work effectively in a variety of institutional and community settings. We have truly come a long way in the last twenty years and we have much to be proud of and much more to contribute. As we move from programmatic perspectives of health education/health promotion/wellness to population health management which strives to integrate primary, secondary, and tertiary prevention concerns for each individual, more change is likely to be required of our profession and its role. These newer expectations bring substantial challenge as well as substantial opportunity for contribution and will provide the challenge that will draw out the excellence in all of us in the years ahead. I hope you share with me the excitement of being part of a field that is truly coming of age. Here's to the next twenty years – may they be as enjoyable, as challenging, as productive and as fun as the last twenty.

Reference

U.S. Department of Health and Human Services, Public Health Services. (1990). Healthy People 2000: National Health Promotion and Disease Prevention Objectives. Publication number 79-55071, p. 177.

Views and Reflections of Health Promotion: Looking into the 21st Century A Historical Perspective

Edward Marc Framer, Ph.D.

In the early 1980's, health promotion was not a defined discipline for one experienced in clinical/behavioral psychology. Certainly, I had no awareness of the term. There was behavioral medicine and health psychology. For example, my first position after finishing graduate school included conducting behavior change classes for morbidly obese patients in a lifestyle change clinic. The clinic blended a medically supervised, very low calorie diet with behavioral/educational classes and a long-term behavioral maintenance program. The work I did was variously defined as behavioral psychology, health education or behavioral medicine. If you were a physician or a nurse, the same clinical picture was likely defined as preventive medicine. Dietitians were describing this work as applied clinical dietetics or something similar. There should be little doubt that those graduating from programs focused on health promotion would find a health promotion way to label the same job. Each guild labels by placing their own guild's contribution at the center of those efforts. The same observation applies to work with patients who needed to stop smoking, lower their elevated cholesterol levels, or manage a large group of health risk factors which included high blood pressure, overweight, elevated blood fats, excessive alcohol consumption, stress, sedentary lifestyle, and a poor diet. Many of these are areas where today's health promotion professionals believe they have a contribution to make. In all these clinical areas, clinicians have traditionally organized their treatments based on their guild's philosophy and basic training, adding information gained from outside readings and specialty workshops they attended.

If the dietitians were hard pressed to justify how they wedged smoking cessation into dietetics, the exercise physiologists were having an equally difficult time justifying why they were talking so broadly about weight loss and nutrition. The psychologists were struggling to explain their expertise in cholesterol reduction or exercise. The solution at the time was simple, each profession placed its expertise at the center of the health care universe. Then, they justified their other efforts by pointing out that other health issues had to be addressed too. As long as they were already working with that patient, why not handle the other interventions. "After all, I'm a clinician" was a frequent phrase used to explain what was happening. Conservative clinicians referred their "tough" patients to other appropriately trained professionals in allied fields. I doubt that anyone thought of referring to health promotion / disease prevention (HP/DP) specialists.

Years passed. I worked on a team developing the "Building A Healthier You" health risk appraisal (Health Management Resources, 1984) and support materials. To the team, "Building a Healthier You" was about health assessment tools and health education materials. The goal was to produce products that enhance and sustained health behavior change. Professional presentations were made at the Association for Behavior Analysis, the Association for the Advancement of Behavior Therapy or the Society of Behavioral Medicine and The Society of Prospective Medicine. Still, there was little recognition of HP/DP. There was a new distinction in my mind as a result of the health assessment work: **Individual versus population health**. Epidemiology was becoming a lot more interesting; so were the fields of medical prevention, and health education.

Between 1985 and 1993 or 1994, I continued to make presentations, train people to do educational groups for weight reduction, smoking cessation, and general risk factor reduction. There was also research in these areas and occasional work with clients. Information sources were the *New England Journal of Medicine*, *International Journal of Obesity*, *Journal of the American Medical Association*, *American Journal of Clinical Nutrition*, and various other journals and books on epidemiology, chronic disease, nutrition, safety, and exercise. The world was "loaded" with good information sources. However, while many behavioral/clinical psychologists still found HP/DP a vague and rather loose concept, the words health promotion / disease prevention were appearing more frequently in the behavioral literature. By middle 1994, ensconced as the Director of Wellness and Prevention for a major health care system, reading now included actual health promotion books and Journals. Two examples of expanded readings are HEALTH PROMOTION PLANNING: *An Educational and Environmental Approach* (Green & Kreuter, 1991) and *The American Journal of Health Promotion*. At the risk of sounding flip, at age 44 I finally discovered HP/DP. What I found, from my idiosyncratic perspective, was not a field in its own right, but a philosophical approach to both individual and population health improvement / health maintenance. Here was a way of thinking about prevention and wellness behavior that utilized working knowledge from a series of fields including medicine, health education, exercise physiology, psychology (clinical, behavioral, educational and counseling), dietetics, epidemiology and organizational behavior.

So, what's the point of my narrative on personal ignorance

of HP/DP? The point, besides the possibility of incredible personal insensitivity, is that **many of us, who practice HP/DP every day of our careers, do not know that HP/DP exists,** or at least did not know it for quite a long time. We were likely to see HP/DP as a sub-process of the fields in which we were trained, not an independent field at all. We were and are psychologists, exercise physiologists, health educators, nurses, dietitians, even a fair number of physicians. We are not trained in HP/DP as a separate subject matter area. We are trained in psychology, exercise physiology, epidemiology, health education, nursing, dietetics or medicine. Stepping aside from our base training is neither easy nor immediate, and from a clinician's perspective, probably not desirable. However, it is absolutely clear that, no matter what occurred on my personal journey, HP/DP was and is being defined by people who see themselves as health promotion students, faculty and practitioners. The clash that this may represent between people who come to health promotion from other backgrounds, seeing it as a sub-specialty within their own fields, and those who see, write and talk about health promotion as a separate field in and of itself, merits exploration.

What is Health Promotion

The working definition of health promotion with which I became comfortable was the one advanced by O'Donnell (1989).

> "Health promotion is the science and art of helping people change their lifestyle to move toward a state of optimal health. Optimal health is defined as a balance of physical, emotional, social, spiritual and intellectual health. Lifestyle change can be facilitated through a combination of efforts to enhance awareness, change behavior and create envi ronments that support good health practices. Of the three, supportive environments will probably have the greatest impact in producing lasting changes" (Page 5).

While not a spectacularly clear definition of anything in particular, it does capture a sense of what health promotion people seem to do and the spirit in which they often work. This holds whether the professionals were directly trained in health promotion or came to it from other fields. It also points clearly to the characteristics and activities that are part of health promotion and to why there may never be a separate and independent field called Health Promotion, which is organized and recognized in the way that many reading this article would probably like it to be.

Characteristics of Health Promotion

- Good science is an integral part of health promotion, but part is still art
- The goal, optimal health, is not focused on cure, but on lifestyle interventions that delay or prevent disease
- Appropriate health promotion programs may touch on the physical, emotional, Social, spiritual or intellectual aspects of being human
- Health promotion favors a learned balance between the various aspects of human behavior and experience
- There are components that directly effect the individual and components that impact the group
- Health promotion activities cover a wide range including
    - Information sharing
    - Behavior change
    - Environmental management
- An acknowledgment that without supportive changes in the environment, new, good-health behaviors are less likely to start or to be maintained

Health Promotion Activities

- **Project/Program definition and design**

- **Health assessment processes**
    - Health risk appraisal
    - Various types of claims data analysis
    - Other specialty health assessments (e. g. physical activity inventories; dietary fat scales; stress inventories, interests check-lists)

- **Data based program/project planning**
    - The integrated results of the various assessments, not personal preference, must drive project planing.

- **Health awareness building, including**
    - All modalities of communication to individuals (e. g. phone calls, letters, faxes, e-mails, payroll stuffers)
    - Group events and strategies (e. g. posters, health fairs, work group health awareness initiatives, media advertising)

- **Intervention strategies**
    - Individual counseling
    - Intervention classes (e. g. smoking cessation, weight management, back safety, etc.)
    - Phone based counseling
    - Environmental change interventions (e. g. working with local restaurants to offer low-fat alternatives; establishing walking trails in a community or worksite)
    - Medical prevention (e. g. immunizations, screening events, rehabilitation programs)

- **Project/Program evaluations**

Health Promotion and health promotion

Let's return to the O'Donnell definition. "Lifestyle change

can be facilitated through a combination of efforts to enhance awareness, change behavior and create environments that support good health practices." **Every health care clinician in the universe thinks he/she enhances awareness, changes behavior and coaches the creation of healthier environments.** To other health care disciplines, Health Promotion seems, functionally, to be a hybridized tool, a cross-disciplinary **approach** to spanning knowledge areas that impact on the creation and maintenance of parallel tracks for individual and population health. They keep this philosophy or approach in their professional toolboxes, pulling it out as the situation dictates. Most feel equally strongly that they know how to use this tool. It is unlikely that other clinicians will discontinue their work in favor of academically trained, health promotion professionals. To do so would take major rethinking of the philosophical and economic underpinnings of half-a-dozen professions. It, therefore, behooves any who see health promotion as an independent field, contributing differently but as importantly as dietetics, medicine, psychology or exercise physiology, to attempt to answer the following questions:

Have you ever seen a state board of HP/DP?
Do you think you will ever see such a state board?
- How will the independent field of Health Promotion be defined?
- Is there a "National Association of Health Promotion / Disease Prevention Professionals" where the standard of admission is a health promotion degree?
- If it were ever constituted, would such an HP/DP society be a large, strong, trend-setting organization?
- What are the principles in which an independent HP/DP organization would ground itself upon? Could it garner broad and ungrudging support for these principles from the majority of members?
- If a legislature were to attempt to define HP/DP as a separate profession, how would it go about it? What are the characteristics of HP/DP that would allow a separate certification, registration or license to be granted?
- How would you write the enabling legislation without violently mashing the mental toes of exercise physiologists, physicians, dietitians, psychologists and others?

Until clear, rational, even elegant answers are available, it may be hard to explain why a separate field called Health Promotion / Disease Prevention should be recognized, legalized and respected for its independent contributions. Until they are answered, it may remain exceedingly hard to define an HP/DP field, with enough inherent structure, which both its practitioners and its allies can comprehend. For those who have obtained health promotion degrees, the distinctions may appear obvious. For many of the rest of us, I assure you, they are not.

Successful health promotion practitioners. I find the following skills, traits and competencies to be important for serious success in this day and time, regardless of academic credential, license, or registration:

- Mental and behavioral flexibility
- A decent health sciences background, including statistics (at least enough to be a thoughtful, knowledgeable "science user," if not a highly competent researcher in your own right)
- Some basic public health and epidemiological training or study (enough to appreciate that all change programs are not individual change programs; enough to understand the additional organization required to succeed with groups and populations)
- Substantial personal reading or a basic course in economics, preferably health economics
- A real appreciation of, and respect for, people and their problems
- A decent understanding of the principles that underlie motivation and human behavior (minimally 3-4 targeted, behavioral and motivational psychology courses)
- At least moderately schooled and skilled in behavior change processes (preferably quite skilled as a result of behavior analysis, behavior modification and counseling skills training)
- Solid project management skills
- Strong analysis and synthesis skills (problem definition, solution finding, program development and program evaluation)
- Some exposure to Continuous Improvement or Total Quality Management
- The ability to appreciate and to work well with a wide variety of other health professionals
- Above average presentation skills
- A professional license or registration in your state (in one of the disciplines that the majority of current HP/DP professionals practice)

If some of the above are missing, one can still work in HP/DP, but the recommendation is that you pick your situations with more care. For example, if you have very modest project management skills, instead of strong ones, don't accept the direct management of a large worksite program. There are likely to be too many logistical snafus. If you don't have a license that certifies you for independent practice in your state, be especially careful about the treatment you promise and in how you describe yourself to others. It is important for the growth of HP/DP that its practitioners, however the field is ultimately defined, not be confused with the quacks and charlatans who populate many of today's weight loss, exercise and behavior change programs at worksites, health clubs, and in the general population.

Present Perceptions of Health Promotion

If present practice is assessed against many of the major

characteristics discussed above, especially the informal feelings that many in business, industry, medicine and the traditional allied health fields (e. g. nursing, physical therapy) might have, health promotion will likely be found wanting. Why wanting? It will be found wanting because I think too many people do not see it as a science, as a needed partner or as a field that contributes to what our society seems to value most — the business bottom line or dramatic "wins" (e. g. Healing the sick or injured). If the average businessperson or physician has an opinion at all, they are likely to view health promotion only on its surface. This is evidenced by how they are likely to speak of health promotion:

- "That diet program over there."
- "They will do a cholesterol for you."
- "You need a physical fitness trainer for a few weeks."
- "It's time to do another health fair."

In my experience, the general population associates health promotion with specific health promoting actions or activities. They do not see an independent, organized science; a science ready and able to contribute to improving the health and well being of themselves and others. There are exceptions to be sure; important ones. For example, studies by Yen & Witting (1991), Manning, Keeler, Newhouse, Sloss and Wasserman (1991), Bertera (1991) and Leigh and Fries (1992) will be immediately recognized by many reading this paper and have drawn the positive attention of business, industry, and sometimes medicine. Chapman's (1991) analysis of the cost effectiveness of wellness is another that many will remember. However, even these have been slow to reach a broad public awareness and are probably read more by "the faithful" than by anyone outside the broader health promotion, and perhaps occupational medicine communities.

The current obstacles and limitations fall into two classes. 1) Too many other people have a piece of the action for the average person (or even professional) to think, "Ah, that is a fine health promotion program." Instead, they think "Great medicine," "good psychology," "excellent dietitian" or "creative medical information project." 2) Most health promotion practitioners, today, are probably not trained in and do not practice a specific science of health promotion. This creates two problems. The first is poor name recognition for the field. The second problem is that many who call themselves health promotion practitioners are not perceived as skilled and disciplined in ways that they need to be. The occasional strong study, and excellent academic departments here and there, do not a field make; yet.

Future Role of Health Promotion

The future role of Health Promotion is not clear. As a very young field, perhaps still a loosely defined field, having significant overlap with preventive medicine, dietetics, psychology, exercise physiology, public health....and perhaps a few more, health promotion's survival as a distinct field is in question. However, the importance of many of the activities that are subsumed under health promotion are not in question. Screenings, information campaigns, worksite programs, community efforts, individual health counseling — all have been recognized as having value in the overall effort to improve the health of individuals and of populations. If all of the various guilds continue to work together, strengthening the empirical foundations of a common health promotion process, then health promotion should contribute more and more to the health of people as we move into the 21st century. And, I predict a number of changes. These include:

- Managed care organizations (MCOs) will become a hot bed of health promotion / disease prevention activities. However, the growth curve will not be a straight line going up. MCOs will embrace, then step back from health promotion in several cycles before health promotion is "in" to stay. Accrediting agencies, for example the National Committee for Quality Assurance (NCQA), will keep MCOs interested, but true commitment will come in stages as health promotion continues to mingle with medical prevention and to act the part of a maturing science. MCOs want data based decision making from their providers, especially their internal providers, which wellness, prevention or health promotion departments are likely to be.
- Work site health promotion and HP/DP in managed care organizations will team together more and more frequently. MCOs, at least the better ones, are building extensive data base capacity. They already understand or are rapidly learning to understand the illness profiles of their customers, especially their large corporate clients. They will be able to supply the science and public health like parts of health promotion to the team. **Prediction for 2010** (assuming consumer backlash does not regulate MCOs out of existence): Worksite programs that resist working with their insurers will lose support and control. Redundant expenditures will not be tolerated by employers or by managed care, and MCOs hold an ever increasing portion of the financial risk unless a company is self-insured. This could make MCOs aggressive proponents of "effective" health promotion.
- Health Promotion will continue to become more and more science based. A chasm may appear like the one that has appeared in the psychological community, where in spite of serious efforts to have it be otherwise, effectively, there are scientists and there are practitioners. Let's all try to keep that divide from occurring. Science is necessary for medical and business acceptance and for sustained progress in the field, behavior change skills are necessary for consistently effecting change. One without the other leads to interesting, but often useless theory and to heroic, but often ineffective health promotion efforts.

• There will be an extraordinary opportunity for health promotion professionals who understand and can organize population-based interventions, not just personal ones. Professionals who are system thinkers will gain in value. Government programs, MCOs and large employer groups are not going to continue to countenance 1:1 or even the 1:10 treatment of individuals, in face to face settings, as the standard intervention modality. They will expect 21st century data systems to help route people to the most efficient types of treatments for each of them. Phone-based and internet-based programming will flourish. High tech and high touch systems will be called upon to help people manage their own health improvement.

• All programs will have evaluation components built in from their initiation.

• Health promotion will be seen as one of the "glue" functions in health care. Conceptually it will subsume patient education, prevention, wellness, and perhaps large parts of the public health systems.

• Conditions that might accelerate these changes would be:

•Broad-based rapid transition to an all MCO medical environment

•Development of new health promotion strategies and interventions with extraordinary effectiveness

•Full insurance coverage for most health promotion interventions

•Increased mandates from government programs (e. g. Medicare) for various health assessment processes and health promotion interventions

•The emergence of state licensed or registered health promotion professionals

Conditions that might delay or limit these changes would be:

•Major MCO backlash which curtails the current acceptance of MCOs

•Culture wide de-emphasis of the value of prevention programs

•Due to dramatic decreases in the cost of illness care

•Due to new understandings that the very behaviors that reduce currently measured risks, actually increase problems later in life

Summary

What health promotion does and accomplishes, in its various incarnations, touches on core issues from our common struggles to be healthy, happy human beings. As quoted in an earlier portion of this paper, **"Health promotion is the science and art of helping people change their lifestyle to move toward a state of optimal health. Optimal health is defined as a balance of physical, emotional, social, spiritual and intellectual health."** As a field, striving to live into that Herculean vision, Health Promotion with a capital "H" and a capital "P" is young and still somewhat unclear about its role, its tools and how it will go about fulfilling the mission and vision implied by O'Donnell's words. The attempt to distinguish what a mature science of Health Promotion will look like, could well give one a splitting headache. However, health promotion, small "h" and small "p" as a:

1) guiding philosophy that appears over and over again in sub-areas of half-a- dozen fields;
2) blended, cross-functional approach to reducing or delaying the onset of preventable illnesses; and
3) torch bearer of the idea that optimal health is something more than the absence of immediately detectable illness; that "health promotion" is alive, well and being performed every day by a wide variety of health sciences professionals.

Long live health promotion.

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The History and Future of Health Promotion and Wellness: A Physician's Perspective

Bill Hettler, MD

My first introduction to the topic of wellness and health promotion actually occurred in May of 1969, while sitting in the commencement exercise at the time of my graduation from medical school. After some initial introductions, an older professor was assisted to the podium in front of the platform committee. He was introduced as John Phair, M.D.

In our four years of medical school education, we had never before seen Dr. Phair. He was a professor of preventive medicine. This specialty had very little presence in the medical school curriculum. We spent the majority of our time learning about disease and treatment modalities.

Dr. Phair began his presentation by saying, "You boys (not gender sensitive, but, after all, there were 2 women in our class of 100), will save more lives, and alleviate more suffering if you never enter the practice of medicine." At this point, there were audible groans from the audience. He went on to say, however, that if we would spend our time helping people learn how to live instead of practicing traditional medicine, we would indeed save more lives and alleviate more suffering.

I have to admit that at that point in my career, I did not see the wisdom of Dr. Phair's words. It is almost 30 years since I heard Dr. Phair give his sage advice. I have since learned that what people do for themselves in the way of lifestyle choices has a much greater impact on their chances of survival than anything physicians are likely to accomplish. My medical school training at the University of Cincinnati College of Medicine was traditional in the late 1960s. We never studied healthy people. We were more interested in diseases and their treatment. I actually had 12 hours of medical education focused on one disease. In our traditional medical training, we were taught to ask each patient, "what is your chief complaint." If individuals did not have a chief complaint, we thought they were wasting our time.

Early Beginnings

Throughout history there have been philosophers, medical researchers, and social leaders who had a clear idea about the importance of promoting the optimal way to live. Some have given this approach the unusual name "orthobiosis." The strict translation of this word is "correct living." This issue is not a moral focus, but is actually based on centuries of direct observation as to which behaviors tend to enhance health status.

One of the first leaders in the modern era of the wellness concept was a physician who served as the director of the University Health Service at the National University in Australia located in Canberra, Australia. Brian Furnass, M.D. (Diesendorf & Furnass, 1976) was one of the principal authors of a book entitled The Magic Bullet, The Social Implications and Limitations of Modern Medicine. In the early 1970's, Brian and his co-authors had a clear vision that the practice of medicine relied too heavily on the magic bullet and too little on assisting people with the more difficult task of living well.

One of the most important publications in the history of North American public health efforts was a 1974 booklet published by the Canadian Minister of Health, Mark Lalonde: A New Perspective on the Health of Canadians. In this publication Lalonde pointed out that the vast majority of the premature death and disability occurring in Canada was the direct result of behavioral choices people had made. This information was widely disseminated through Canada and quickly passed across the border to the United States. Public health officials throughout the United States began to look critically at the materials and the conclusions of this report. Ironically, much of the scientific research done to document the findings in this report were created by American health officials working for the Centers for Disease Control in Atlanta.

Very soon after Lalonde's report was published, the U.S. Surgeon General's report entitled Healthy People was released, which emphasized many of the same points made in Lalonde's publication. One of the major efforts to come out of the Healthy People document was the clear recognition that smoking had become the most important public health problem facing Americans. It had greater impact on premature death and disability than any other single, modifiable risk factor. The history of smoking and the role of advertising in America is very interesting. Originally, smoking involved pipes and cigars. Cigarettes were considered something a sissy would use. They were hand-rolled and relatively expensive. Real men smoked cigars and pipes. However, in the later part of the 19th Century, a brilliant engineer named James Bonsack developed a cigarette rolling machine. This was adapted from a wool feeder of a carting machine and it replaced 48 hand rollers. This was the beginning of a major industry which has had profound detrimental effects on the public health of Americans and, for that matter, populations throughout the world.

Ironically, in the early years of tobacco marketing, physicians were helpful allies. Physicians, not yet privy to the research findings, were very accommodating to cigarette advertising campaigns. Typical magazine ads espoused that "more doctors smoke camels than any other cigarette." Phillip Morris produced its famous "An Ounce of Prevention Is Worth A Pound Of Cure" ad, in which it stated that "Philip Morris are scientifically proved far less irritating to the nose and throat." One has to ask, "Less irritating than what? Sulfuric acid? Hy-

drochloric acid? Sulfur dioxide?" It was later that physicians were replaced by famous sports personalities and other public figures posing with tobacco products. Unfortunately, many of the personalities succumbed to diseases associated with the use of these products.

Advertising and Social Change

Advertising Age is a trade publication of the ad industry. If one is at all interested in the efforts being made to change American behavior, this is an important publication to read. The best psychologists in America and the most creative minds on behavior change do not work in our clinics and hospitals, they work for advertising agencies. Let's review some of the successful efforts of the past.

In the early 1930's, a brilliant executive working for a tobacco company discovered that half of American adults were not smoking and there really was no reason why they couldn't become smokers. So an industry-wide campaign was developed to try to get women to smoke. One of the first advertisements designed to encourage women to smoke was an ad for Lucky Strike. In the ad the woman is not actually smoking. That would have been too big a jump from the cultural norms of the time. Psychologists, even in the early 30's, knew that it would not be productive to show a woman smoking when that was not culturally acceptable. One of the other companies that produced Chesterfield cigarettes created ads that showed a young woman asking her male smoking friend to "Blow Some My Way."

Later, the tobacco industry hired famous movie stars, opera singers, and females that were socialites in the major cities to pose with tobacco products and talk about things such as "Not One Single Case Of Throat Irritation Due To Smoking Camels." Isn't it ironic that the #1 cause of throat cancer is this exact same product?

Most Americans are very familiar with the successful Virginia Slims ads. We have helped women...."come a long way." Not only Virginia Slims, but a number of other new tobacco products were created specifically to attract the attention of women and have been very successful. Lung cancer quickly became the leading cause of death due to cancer for women as well as men.

Early Physician Pioneers

In United States in the early 1960's, a little-known public health official by the name of Halbert Dunn, M.D., Ph.D., began to collect a series of presentations he gave under the title "high-level wellness," and authors would later credit Dunn as the founding father of the Wellness Movement. He eventually published this collection of 29 short talks on key aspects of Wellness under the book title High Level Wellness, in which he envisioned Wellness as an integrated method of functioning oriented to maximizing an individual's potential within the environment where he is functioning. Referencing the writings of Abraham Maslow, Hans Selye, Carl Rogers, Gordon Allport, Eric Fromm, S. I. Hayakawa and Sydney Jourard, Dunn also outlined his vision for the future: a new world in which science, faith and the destiny of man would blend with a oneness of life, and man's never-ending search for truth directed toward improving the world for mankind as a whole.

In 1970 Lou Robbins and Jack Hall, two physicians associated with the Methodist Hospital of Indiana, introduced the concept of health hazard appraisal in their the book entitled, How to Practice Prospective Medicine. This was a futuristic oriented methodology that represented the first organized effort at using national center for health statistics data, along with patient histories, to compute an estimation of an individual's future risk of death.

Lou Robbins and Jack Hall (1970) recognized early in their health promotion efforts, that if physicians were going to have a significant role to play in lifestyle improvement activities, it would most likely be delegated to other staff within the medical clinic. In their model of prospective medicine, Robbins and Hall also recognized that extending life expectancy through improving the individual's survival chances cannot be considered a simple task. Understandably, family physicians could not and would not drop their concern for the sick patient in order to provide a prognostic survey. Nonetheless, physicians are no stranger to risk. For every patient they see, there is a built-in alarm system which warns physicians that their patient is carrying a high risk. Without the information received in medical school on risk of death and disability, the physician would find it impossible to practice medicine. By the same token, ten-year risk in the absence of disease is knowledge the physician must have if one is to counsel the patient on survival chances beyond present illness.

Two other pioneers in the health promotion field, John Travis and Don Ardell, served to carry on the early work and ideas of their earlier counterparts Dunn, Robbins and Hall. As a young physician enrolled in a preventive medicine residency program at Johns Hopkins University, Travis was very impressed with the ideas presented in Halbert Dunn's book and introduced to the futuristic oriented methodology and the concept of health hazard appraisal developed by Robbins and Hall. Ardell, a young Ph.D. candidate, developed a self-directed doctoral program focused on positive health. As a health planner, he became frustrated when he realized that most of his efforts were actually organized around the issue of providing disease care for people with problems. In 1977 he published his idea of an alternative model in the book High Level Wellness, An Alternative to Doctors, Drugs and Disease (Ardell, 1977). Both Travis and Ardell conducted workshops on prospective medicine and disease prevention throughout the United States and other countries, providing the groundwork for the development of the university-based programs and professional organizations which followed.

Emerging Professional Conferences and Organizations

During the early 1970s, the physicians at the University Health Service at the University of Wisconsin at Stevens Point began to use computerized lifestyle assessment instruments as part of the entrance health requirements for the university. The University of Wisconsin-Stevens Point (UWSP) had a student development focus which had been introduced by its President, James Albertson. Albertson had the idea that a university should assist students with learning how to live their lives, as well as prepare them for some future career. As a result, the university became one of the early leaders in the use of health hazard appraisal and prospective medicine.

As one of the physicians at UWSP, this author began work on the development of the Lifestyle Assessment Questionnaire (L.A.Q.). for use within the university program. A lengthy questionnaire, the L.A.Q. had a number of sections including a wellness inventory, health hazard appraisal, a medical alert section, and a component in which the user could select information on topics for personal growth. The L.A.Q. was eventually computerized, made available nationwide, and began to generate interest from other parts of the country. Specifically, people began to ask for training related to the use of the L.A.Q. and other health promotion techniques developed at the University of Wisconsin-Stevens Point. As a result, the suggestion was made to hold a national conference on the subject of wellness promotion strategies. Hettler, now Director of the University Health Service, and a colleague, Robert Bowen, had been part of two summer workshops addressing wellness and decided to identify the next conference as the Third Annual Wellness Promotion Strategies Conference. A brochure was quickly created and mailed to a wide variety of mailing lists throughout the United States. They were surprised that more than 250 people registered for the 1978 conference.

This was the beginning of what was to become the National Wellness Conference. The conference has continued to grow over the years to the point that it currently attracts 1600 people each summer. In the early years a large number of participants made regular requests that the organizers of the conference create a membership organization for those professionals who enjoyed participating in the annual conferences. The response was the eventual creation of an organization called the Organization of Wellness Networks.

The Organization of Wellness Networks was a precursor to the National Wellness Association. Initially it was named the Institute for Lifestyle Improvement, as all financial services for the Institute were provided by the University Foundation at the University Wisconsin-Stevens Point. Later, as revenues continued to stream into the National Wellness Institute from its various activities, the Board of Directors of the University Foundation requested that the National Wellness Institute split off from the Foundation. As this revenue had to be treated as unrelated business income, the Foundation's board felt that this might compromise its tax-exempt status. The National Wellness Association remains as one of the premier professional organizations in the field of health promotion dedicated to providing a network for those committed to an interest in wellness

At the same time that the National Wellness Association was evolving, another national group also emerged. Many of the major corporations in the United States had begun to recognize the positive benefits of exercise and health promotion activities by the early 1980's. This group of professionals evolved from among the leaders of fitness programs that had been established in business and industry and included corporate leaders and pioneer programs in health promotion such as Sentry Insurance, Kimberly Clark, Xerox, Conoco, Texaco, Johnson & Johnson, Tenneco, Johnson Wax, Pepsi, and General Foods, among others. The initial name selected for the area was The American Association of Fitness Directors in Business and Industry (AAFDBI).

AAFDBI held annual meetings, initiated a professional journal, developed regional associations, and a number of other services to members. An honorary fellow program was created to recognize significant leaders in the field of corporate health promotion. AAFDBI later changed its name to the Association for Fitness in Business or AFB for short. However, after a few short years the association again changed its name to the Association for Worksite Health Promotion.

The evolution in name changing was reflective of the changing mission and emphases for professionals working in corporate health promotion. The initial organization was very focused on fitness as its major activity but increasingly began to expand its focus to include a broad range of health promotion topics. Today the association meetings focus on the broader range of health promotion topics similar to those presented at the National Wellness Conference. The Association for Worksite Health Promotion (AWHP) also developed a strong network of regional associations. These regional organizations provide training opportunities on a more local basis.

Of particular significance, the initiation of a research agenda under the leadership of members of AWHP has resulted in studies published in a wide variety of professional journals, including its own, The American Journal of Health Promotion. The Journal has a large volunteer editorial staff representing a broad range of health promotion professionals and has become one of the most important publications in the field of wellness and health promotion. Any serious research involving wellness and health promotion can usually be found in the American Journal of Health Promotion.

Future Thoughts

There is a fundamental change that is occurring within the field of health promotion. This change involves the massive investment that is being made to create health promotion assessments and information. The delivery of these assessments and content via the information superhighway will have a dramatic impact on the ability of the average person to assume greater responsibility for their health and well-being.

As I look to the future, I am optimistic and excited. One of

my early heroes was Buckminster Fuller. Bucky, as he was known to his friends and admirers, had a vision that someday people anywhere in the world would be able to listen to the best teachers on any subject, 24 hours a day, in their own home, in the language of their choice. The technology to make that happen exists as we close out the 20th century. While we may still have serious problems with access to certain parts of the world, this too will change over time. Our efforts in health promotion have been relatively unsophisticated until recent times. Typically, health promoters have simply told people to do things they already knew they should do and, in many cases, wished they were able to do. As we develop more sophisticated tools to assist us in identifying the specific personality type and learning preferences of our clients, we can improve on the success rate for those clients seeking assistance in extending useful longevity.

The merging of the fields of telecommunication, educational technology, microprocessing, and low-cost video production will enhance the resources available to assist with lifestyle change.

Physician-directed medical self-care can be delivered through a variety of systems. Some of these include: The Internet and World Wide Web, Interactive CD-ROM, videotape resources, audio tape systems, automated fax-back systems, computerized decision support software, dedicated medical self care television networks, topic-specific online chat rooms and forums, newsletters and journals, and talk radio.

As the medical profession becomes more comfortable with computer technology and other audiovisual delivery systems, this massive increase in processing power and storage capacity can assist us in our goals to improve the quality of life and lower the cost of care for the patients we serve. For the time being, the Internet and World Wide Web seem to be the most efficient delivery system. The dramatic reduction in the cost of CD-ROM recorders, video capture technology, and multimedia editing software have made it possible for individual physicians, nurses, and patient educators, to create their own multimedia self-care resources. Using multimedia-editing software, one can create customized patient education materials.

Just 10 years ago the cost of creating videodisc interactive technology was greater than one hundred thousand dollars per topic. When it comes to educational technology, there are hundreds of companies actively working to create user-friendly software that physicians can use to create practice specific physician directed self care materials. The emphasis today on chronic disease care management and demand management will drive greater utilization of these resources in the larger managed-care arena.

The use of microcomputers to create customized videotape resources is also a reality as this chapter is written. This is a grade school skill in many locations. As the students in our schools today graduate and seek jobs, it will be realistic for the larger clinics to include customized videotape production as one of the expectations in the job description of health educators or medical self-care leaders.

Each day in America, there are hundreds of high-quality video productions created by news programs in local television stations. Many of these programs could be captured, cataloged, and stored for later use by medical self-care production facilities. Obviously, a system must be created to give proper credit and compensation to the original producers of such materials. The ability of current technology to manage a database of these resources makes this a feasible concept.

Audiotape production has also enjoyed significant technological advances. Microcomputers, high-quality microphones, and editing software make it possible for any health care provider to create customized decision support audio tapes that can be given to the patient to reinforce the instructions or procedures recommended for the care of their problems. The cost of production and duplication of audiotapes is minimal.

Another innovation that can work in many locations is automated fax back systems. There are turnkey systems available that enable a medical office or clinic to provide automated patient information at very low cost. The systems are easily customized and can be managed by clerical staff. The health professionals must create the content, but once this content is created, patients can easily access instructions or materials of their choice through fax technology.

There are similar automated systems that involve voice messaging. Many of the systems enable the user, by touch tone input, to select specific information of their choice. This technology is also cost-effective and is being used particularly in the technical support area of computer companies. Logical tree structures are created that enable users to be quickly moved to the resources that will assist them in solving their problems. This same procedure can be used to assist medical patients in finding the answers they need to make decisions in a self-care mode.

The future is coming. We can't stop the accelerated rate of change. We can, however, choose how much we might personally influence change in being consistent with the visions of the early leaders in the field and in enhancing worldwide optimal health.

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Identification of Standards of Practice: Evidence of the Evolution of Worksite Health Promotion from a Discipline to an Emerging Profession

Jacqueline Hooper, Dr.P.H.

Introduction

The notoriety of worksite health promotion programs has grown over the years, largely fueled by the increase in the number and scientific support of such programs. Results of a 1992 national follow-up survey showed a dramatic increase in the prevalence of worksite health promotion activities. Survey findings indicated that the percentage of companies offering worksite health promotion activities in the continental United States increased from 62% in 1985, to 81% in 1992, with the greatest increase seen in companies with at least 750 employees where the percentage increased to 99%. Since implementation of the first survey, the investigators of the study credited employers' heightened interest in worksite health promotion programs to documented reductions in health care costs, absenteeism, and worker turnover and improvement in employee productivity and morale (U.S. Department of Health and Human Services, 1992).

Evolution of the Characterization of Worksite Health Promotion

Parallel to the recognition paid to the growth and benefit of health promotion programs at the worksite, worksite health promotion as an entity also has grown in renown. A cursory review of literature from 1972-1998 reveals that reference to worksite health promotion appears to have evolved from being characterized as a movement (Cooper, 1977) or a field of study (Kaman, 1989), to being referred to that of a discipline (Golaszewski, Couzelis, Corry, Baun, & Eikhoff-Shemak, 1994) or an emerging profession (Association for Worksite Health Promotion; 1995). Although use of such terminology sometimes is interchanged, results of the review suggest a trend in which the characterization of worksite health promotion has evolved in sophistication.

For illustrative purposes, an argument for existence of such a trend can be made with the use of the aforementioned review of literature, a continuum and a dictionary (DeVinne, 1990). On a continuum (Figure 1), reference to worksite health promotion as "a movement" would be located at the starting point, while characterization as "a profession" would be found at the end point.

Figure 1. Continuum Illustrating the Characterization of Worksite Health Promotion from 1970-1998

Movement *Field of Study* *Discipline* *Emerging Profession* *Profession*

1970—1975—1980—1985—1990—1995—1998

Historically, a superficial inspection of select literature in the 1970's revealed that worksite health promotion programming focused primarily in the area of fitness (Bjurstrom & Alexiou, 1978). During that decade, worksite health promotion was frequently referred to as a 'corporate fitness movement' largely due to the fact that corporate fitness as an entity was spearheaded by a small number of professionals convened by the President's Council on Physical Fitness in 1974 (Association for Fitness in Business, 1983). Characterization of worksite health promotion as a movement seems to be fitting for that time period as evidenced by the definition, "the activities of a group of people to achieve a specific goal" (DeVinne, 1990, p. 1112).

From the late-1970's to mid-1980's, as the scope of worksite health promotion programming broadened beyond fitness to include a myriad of other health-related activities (O'Donnell & Ainsworth, 1984), and the number of worksite health promotion-related academic courses increased, reference to worksite health promotion shifted toward that of a field of study. Congruence with the definition, "a topic, subject, or area of academic interest or specialization," (DeVinne, 1990, p. 621) seems to indicate that characterization of worksite health promotion as a field of study appears suitable for that time frame.

In the late-1980's to mid-1990's, parallel to the steady increase in the number of worksite-based programs and a proliferation of worksite health promotion-related academic options of study (Chenoweth, 1987), reference to worksite health promotion shifted toward that of a discipline. Again, inspection of the meaning of the word discipline, "a branch of knowledge or teaching"(DeVinne, 1987, p. 484), reveals that such a characterization appears fitting at that time.

From the mid-90's forward, although reference as a discipline pervades the literature, due to several initiatives undertaken to professionalize the discipline, such as the creation of standards of practice (Golaszewski, et.al., 1994; Worksite Health

Promotion Alliance, 1997), mention of worksite health promotion as an emerging profession is beginning to be seen. Inspection of the definition of the word profession, "a body of qualified persons in a specific occupation requiring specialized training," (DeVinne, 1987, p. 1349) as well as efforts directed at developing professional standards, appears to appropriately characterize the stage of professionalization that worksite health promotion is nearing, that of an emerging profession.

Progress Toward Recognition as an Emerging Profession

It could be argued that in today's occupational climate, recognition as a profession is highly desirable. Members of recognized professions, such as medicine and physical therapy, typically enjoy enhanced status within the community and economic security (Larson, 1977). Studies of established professions have shown that steps associated with the professionalization process are multi-faceted and very deliberate (Leiberman, 1956; Livingwood, 1996).

Research indicates that the evolution of a profession often is achieved by reaching specific procedural milestones. Example of such critical procedural milestones that must be met includes the development of a means to identify standards of practice within a profession, and a mechanism to ensure that services are delivered at the level of the practice standards. Frequently, the creation of such standards occurs as a result of the spearheading influence of one or more national associations formed by professionals within the emerging profession (Livingwood, 1996).

In worksite health promotion, the Association for Worksite Health Promotion (AWHP), formerly known as the American Association for Fitness Directors in Business and Industry (AAFDBI) and as the Association for Fitness in Business (AFB), has been the catalyst that has driven the process of professionalization. Review of the achievements made by AWHP over the course of more than two decades reveals that the standards of practice and credentialing procedural milestone, critical to recognition as a profession, has been nearly reached.

Progress Made Toward Identifying Standards of Practice and a Credentialing Mechanism

Historical Overview

In 1990, the AWHP Board of Directors first recognized the importance of creating practice standards. To this end, in 1992, the Board appointed a Task Force, comprised of worksite health promotion professionals and academicians, to initiate the process of identifying professional standards and a corresponding credentialing mechanism. Although it was recognized that professional standards needed to be defined at the director, intermediate- and entry-levels, due to limitations in resources, the group initially chose to limit their scope of work to the director-level.

In 1993, in conjunction with the work being done in the area of professional standards, the Board spearheaded the inception of the Worksite Health Promotion Alliance. The Alliance, which is still in existence today, is a coalition-type organization comprised of individuals and representatives from associations from academia, industry, worksite health promotion, and the media. At the onset, the group was convened in response to the Clinton Administration's efforts in the area of health care reform. The initial charge of the Alliance was to lobby key law-makers and provide convincing testimony in attempt to influence the President and Congress on the role of worksite health promotion in health care reform. As a means to achieve this end, the group began development of guidelines for the creation, delivery, and adaptation of innovative and effective health promotion programs in various work settings (Worksite Health Promotion Alliance, 1997).

Within the last few years, AWHP has made identification of standards of practice, and the identification of corresponding credentialing mechanisms, a Board priority. Subsequent to this decision, the Board broadened the scope of work of the original task force on professional standards and melded it into an umbrella group called the Standards Committee. Besides a committee chairperson, the Standards Committee is comprised of five members who each chair one of five Task Forces on Program, Professional (Director-level, Intermediate-level, or Entry-level), or Academic Standards. To date, the scope of work of and recent accomplishments achieved by each of the Task Forces has provided impetus for recognition of worksite health promotion as an emerging profession.

Task Force on Program Standards

In 1997, a Worksite Health Promotion Alliance task force, consisting of a mix of Alliance members and consultants from trend-setting worksite health promotion programs nationwide, completed the preliminary draft of a 30-paged document that detailed standardized guidelines for the creation, delivery, and evaluation of worksite health promotion programs. The motive for the creation of program standards grew out of frequent requests from organizations for guidance in the development, implementation, and evaluation of worksite health promotion programs. The standards outlined in the document contain a compendium of the best practices of seasoned worksite health promotion programs with documented effectiveness. An article in Worksite Health provides a summary of the draft recommendations for program standards (Ferko-Adams, 1998).

***T*ask Forces on Professional Standards**

As evidenced by other professions that have delineated professional practice standards, the process of developing the standards is lengthy and complex. Frequently, as is the

case with AWHP, the practice standards provide a framework in which a predetermined level of knowledge and skill competencies required in a given vocation can be delineated. Ultimately, this competency framework will serve as the template for the development of a credentialing mechanism such as certification or licensure.

In order to ensure consistency in the development of the varying levels of professional standards, AWHP standardized the process in which the standards are being developed at the director-, intermediate-, and entry- professional levels. Additionally, to ensure that the standards are valid and represent the best of practices within the industry, a core of academicians and worksite health promotion practitioners are utilized throughout the standards development process.

Generally speaking, the process that is currently being utilized by AWHP in the development of professional standards consists of four phases. In the initial phase, the roles and responsibilities of a practitioner at a given level of employment (director,- intermediate-, or entry-level) are delineated. The second phase, consists of verifying that the roles/ responsibilities delineated truly reflect the standards of practice in the industry. In the third phase, the knowledge and skill competencies required for effective performance of these roles and responsibilities is determined. Lastly, the fourth phase consists of validating the competencies by ensuring that they mirror what is required to perform the roles and responsibilities at a predetermined standard of practice.

Often, as is the case with AWHP, preparation for credentialing will follow completion of the development of professional standards. For obvious reasons, selection of either certification or licensure depends on the level of professionalization achieved. Certification, the mechanism available to entities like AWHP, provides a mechanism by which a professional association can grant recognition to an individual who, upon satisfactory completion of a competency-based exam, can demonstrate the ability to deliver a predetermined standard of practice. In contrast, licensure is a process by which an agency of the government, such as a state, grants permission to an individual to practice a given profession by certifying he/she has demonstrated the ability to deliver a predetermined standard of practice.

Currently, the three Professional Standards Task Forces are at differing phases of completion of the development of professional standards and a certification mechanism.

Director-level

Of the three groups addressing professional standards, the director-level Task Force has made the most progress. To date, the development of a 55-page professional practice standard framework has been completed (Couzelis, Baun, Leutzinger, & Rager, 1993). Summaries of the role delineation for a worksite health promotion director (Golaszewski, 1994) as well as a recipe-version of professional practice "guidelines" (Association for Worksite Health Promotion, 1995) have been published for use by the worksite practitioners. Additionally, the Task Force recently has begun efforts toward seeking assistance in the development of a national director-level certification examination. The Task Force hopes to pilot-test the certification exam within the near future.

Intermediate-level

To date, the intermediate-level Task Force has completed the first three phases of AWHP's professional standards process. The roles and responsibilities of an intermediate-level worksite health promotion professional have been delineated and verified to reflect current standards of practice in industry. Furthermore, a draft of the knowledge and skill competencies required for effective performance of the roles and responsibilities of an intermediate-level professional has also been finished. With the involvement of nearly 500 worksite health promotion practitioners and academicians, the Task Force is currently in the process of completing the validation of the competencies. The Task Force plans to publish the validated competencies within the year.

Entry-level

Similar to progress made at the intermediate-level, the entry-level Task Force has completed the first three phases of the professional standards process. The roles and responsibilities of an entry-level worksite health promotion professional have been delineated and shown to reflect current standards of practice in industry. Furthermore, a draft of the knowledge and skill competencies required for effective performance of the roles and responsibilities of an intermediate-level professional has also been finished. Currently, the Task Force is in the process of validating the knowledge and skill competencies. Publication of the validated competencies is forth coming.

Task Force on Academic Standards

Unlike the other standards task forces, the Academic Standards Task Force was assembled within the year and a scope of work just recently determined. The initial goal of the group, which is comprised of academicians from a cross-section of worksite health promotion-related education programs in the nation, was to identify the mission of the Task Force.

The Task Force identified its mission to be two fold. One charge is to delineate academic standards for worksite health promotion-related degree programs that parallel the competencies that underpin the previously mentioned professional certifications being developed. The other charge is to create a mechanism that would encourage institutions of higher education to offer worksite health promotion curriculum that would mirror these academic standards.

Since not all three professional practice standards and their corresponding certification mechanisms are yet complete, the

Task Force decided to first focus attention on the identification of a mechanism in which academic standards could be administered. To this end, the Task Force determined the need to identify different mechanisms in which academic standards could be administered, and a consensual process in which such a mechanism could be selected.

To date, the Task Force completed a comprehensive review of mechanisms in which academic standards are administered by other professional health-related associations. Associations in athletic training (National Athletic Trainers Association), nursing (National League on Nursing), recreation (National Recreation and Park Association), health education (Society of Public Health Educators and American Association for Health Education), public health (American Public Health Association), dietetics (American Dietetic Association), and physical therapy (American Physical Therapy Association) were reviewed.

Because of the potential impact of the selection of an academic standard mechanism, the Task Force recognized the need to identify a process in which faculty associated with worksite health promotion academic programs would ultimately be the ones who identified the preferred mechanism. The Task Force elected to use a modified Delphi method of inquiry that has been successfully used in a similar undertaking that utilized a group of geographically disperse participants. In a recent study directed at standardizing the use of the term worksite (Cox & Hooper, 1998), the Delphi method proved to be an easy-to-use, low cost instrument that facilitated brainstorming of ideas, clarification of perspective, and achievement of group consensus in three sequential rounds of survey inquiry.

At the time of this writing, the Task Force has administered the first of three surveys. It is anticipated that the total Delphi process will be completed and that recommendations for academic standards will be made to the AWHP Board of Directors in 1999.

Importance of Standards of Practice and Credentialing in the Professionalization Process

Creation of program, professional, and academic standards of practice, and a mechanism to encourage compliance to such standards, potentially has a myriad of benefits that ultimately should contribute to recognition of worksite health promotion as an emerging profession.

The recent development of program standards, that provide guidelines for the development and maintenance of health promotion programs at the worksite, should increase the credibility and renown of the profession as it continues to emerge. Hypothetically speaking, adherence to the program standards by organizations nationwide should ensure high quality worksite health promotion programming that effectively meets the individualized needs of employees and organizational needs of employers alike, while contributing to an enhanced health and fiscal status of society as a whole. Future creation of a mechanism that would encourage organizations to adhere to the standards, such as an 'outstanding program' award system, eventually should encourage compliance to the standards as well as to provide opportunities to continue to benchmark the components of effective worksite health promotion programs. History has shown that organizations are more apt to create and maintain worksite health promotion programs as a body of research-based evidence that delineates the effectiveness of such programs accumulates. In general, heightened awareness of the effectiveness of worksite health promotion programming by employers, industry, and society has led, and should continue to lead, to further proliferation in the number of programs nation-wide, as well as a greater need for qualified professionals to direct such programs. Ultimately, as the number of worksite health promotion professionals grows, so does recognition of worksite health promotion as a profession.

The ensuing completion of professional standards of practice, and a mechanism that provides evidence that professionals have the knowledge and skill competencies needed to meet those standards of practice, also has the potential to increase the credibility, visibility, and status of worksite health promotion to that of a profession. Similar to program standards, the existence of professional standards of practice should lend to the cultivation of new, and the maintenance of existing, programs as well as an increased number of practitioners in worksite health promotion. Upon the completion, unveiling, and extensive marketing of the professional standards, similar to what has occurred in other professions, it is expected that employers will preferentially hire certified practitioners. As certified director-, intermediate-, and entry-level worksite health promotion professionals enter the job market, and organizations with certified professionals as employees are recognized as having blue-ribbon health promotion programs, the recognition and visibility of the certifications should become established and steadily increase.

Additionally, preferential hiring of certified professionals should also lead to the development of standardized job titles and job descriptions. With a greater presence of certified worksite health promotion professionals in the workforce, job titles should mirror the title of the certification (e.g. Health Promotion Director) and job descriptions should reflect the standards of practice that such a professional would be expected to perform. Over time, the esteem associated with certification as well as the entrenchment of standardization job titles on the part of employers should contribute to the recognition of worksite health promotion as a profession.

Creation of academic standards, and identification of a mechanism to encourage compliance with such standards, also contributes to the professionalization of worksite health promotion by linking education to the workplace. Ultimately, the future development of academic standards will provide institutions of higher education an opportunity to deliver curriculum that readies students for professional certification and employment in worksite health promotion. With the

development of undergraduate and graduate curricular frame works that parallel the competencies underlying respective professional certifications, course content could be created or revised to match classroom instruction with the knowledge and skills required by worksite health promotion practitioners in the workplace.

In addition, similar to other professions with established accreditation standards, creating an accreditation-like mechanism would encourage universities and colleges with worksite health promotion-related coursework to fashion their curriculum in accordance to the academic standards. Matching educational preparation with job competencies then should benefit graduates, prospective employers, and institutions of higher education alike. Hypothetically, graduates of education programs that adhere to the yet-developed academic standards should more readily pass the professional certification exams than students graduating from institutions that did not prescribe to the recommended curricular guidelines. Additionally, with increased esteem of professional certification on the part of the prospective employers, graduates of accredited academic programs should also more readily secure employment in a worksite health promotion setting.

Moreover, it follows, if the aforementioned benefits come to fruition, with the increasing trend for documentation of student-related outcome data, like job placement and professional certification examination pass rates continuing, it appears worksite health promotion education programs could benefit from modeling their curriculum in accordance with the academic standards. Lastly, although there are pro's and con's to mandatory academic standards, in times of financial cut-backs, mandatory accreditation can safeguard an education program from having faculty and other resources downsized or eliminated.

Conclusion

A cursory review of literature over a quarter of a century indicates a shift in the characterization of worksite health promotion from that of a movement toward an emerging profession. Additionally, inspection of the literature shows that the existence of standards of practice and a corresponding credentialing mechanism are two of several traits found in established professions. Summary of the accomplishments achieved by AWHP indicate that program, professional, and academic standards are completed, or near completion, and steps toward creation of respective credentialing mechanisms are forthcoming. Hence, although other criteria of established professions, such as the development of a nomenclature and code of ethics, have not yet been undertaken, it appears that worksite health promotion has made sufficient progress in the professionalization process to be characterized as an emerging profession.

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Fitness Education And Wellness In The 21st Century: Hospital Setting

Karen Pedevilla

Historically, wellness and health education focused on the medical model. Medical interventions and health care relied on pharmacology and surgery. Care was based on incidences of disease. The patient fell ill, sought out treatment by the medical provider, and was possibly cured.. Little, if any, health education or wellness intervention took place. The medical provider was viewed as the authority. The care was reactive and relied only on the physician. Patients viewed themselves as passive recipients of services, and felt obligated to follow the recommended plan. Professionally, health educators were typically nurses. They had an interest in patient education that focused on intervention as opposed to prevention. Hospitals didn't hire certified health education specialists and/or professionals with degrees in health education.

In the 1970's, some visionary hospital administrators and physicians started to develop a holistic health care focus. Wellness and fitness centers grew out of this movement in the health system. Beginning with the nation's fitness revolution, aerobic exercise became the "buzz" word. While catering to the"baby-boomers," diet and exercise programs increased the general public's understanding of self-care and personal responsibility for one's health. Other trends emerged at the same time, including aerobics, jogging, and commercial fitness clubs.

The health care profession will continue to provide acute care services. However, a paradigm shift is occurring. The emphasis now is toward keeping people healthy through wellness promotion, early detection, and prevention. Wellness and disease prevention activities are essential to a healthy lifestyle. Hospital wellness now emphasizes the prevention of illness and attempts to improve continuity of care for those who move from treatment toward maintenance of good health for a lifetime.

More recently, hospital health care educators have been asked to be service providers in many settings not affiliated with the hospital. This multi-setting, outreach approach is becoming more popular as health care systems strive to become models for the community through promotion of the healthy lifestyle. Many hospitals are offering health promotion not only to their employees and patients, but to members of the community, industry, and local businesses as well. Hospital based fitness centers offer an array of services. Illness prevention strategies such as physical fitness, nutrition, stress management, and mental and emotional wellness are continually being developed, as individuals are increasingly becoming empowered to be the responsible for their own well-being. The expert on disease is still the traditional medical provider. However, a partnership is evolving using wellness, health education, and skill building as the basis for creating individual self responsibility. Patients are encouraged to use fitness centers for a portion of their treatment for physical therapy, rehabilitation, cardiac rehabilitation, etc. This approach helps the patient recover from their injuries/illnesses more quickly than with conventional rehabilitation settings. It also serves the regional community by integrating programs and services which comprise the wellness continuum and encourages individuals to develop healthier lifestyles once formal treatment has been completed. Hospital-based programs now integrate disease prevention, health promotion, health education, and community health improvement services, all of which changes the focus from sick care to health care. In other words, hospital wellness programming currently strives to provide a well-rounded approach to preventive health care. The end result of these interventions, using evaluation, education, and behavior modification, is to maximize the health potential of the individual.

Hospital-based programming has now moved from reactive health care to proactive health care with the focus on early diagnosis, treatment, wellness, and prevention. Also, there has been a move from the traditional reliance on physicians only, to reliance and partnerships with other health care professionals, including health educators.

One of the key elements in the health care delivery system and continuum of care is the medically based health and fitness center. By targeting high risk individuals, medically based health and fitness centers offer benefits by providing wellness and disease management programs, which opens up new opportunities for the health educator. Participants have now realized the benefits of good health. These include the following:

* Improved physical appearance
* Increased energy and stamina
* Better self-image
* Decreased risk for heart disease, cancer, and other lifestyle disorders
* Enhanced performance on the job, at home, and at play

A Look to the Future of Hospital Based Health Promotion

Hospitals have attempted to position themselves as leaders in prevention by developing information systems and

integration of system-wide prevention efforts for both the community and for their own employees. Wellness and health education programs in the future will increasingly consist of interdisciplinary health care teams, linking wellness and health management to employee benefits. They will be more cost effective, promoting wellness and prevention by collaborating with health care providers and community agencies. These integrated teams will be made up of various professionals within a health system to offer input towards services of health promotion. These future wellness teams need to include, among others, members representing nutrition services, human resources, employee health, administration, nursing education, health education, exercise physiology, as well as a member from an Employee Assistance program or bargaining unit representative. These programs will assess risks, reduce risks, identify health care costs, use incentives, and measure outcomes.

By positioning wellness as a marketing tool in managed care, the value of wellness programs as a key component in comprehensive cost containment strategy may also be realized. The long-term benefits attributed to such programs include: reduced absenteeism, decreased turnover, decreased medical claims, increased productivity, enhanced employee relations, improved employee health and fitness and recruiting advantage. There will be a seamless system to reduce health care costs and increase satisfaction. A patient may very well enter the health care system and move along a continuum of services that will transition them from illness to wellness. For example, a patient with a spinal cord injury will move from intensive care, to rehabilitation, to out patient services such as orthopaedic sports therapy, and finally to a fitness/health center. Ultimately, the continuum will also move the client from being dependent on medical care providers towards individual responsibility and independence.

In addition, hospital based fitness and wellness programs will increasingly be an integral part of the way hospitals serve their communities through prevention, health education, and rehabilitation. The hospital will focus on business diversification, as new revenue sources are being explored. With declining reimbursement, health care providers are expanding and developing new, nontraditional, self-pay business opportunities that are compatible with the mission of the hospital. The medical fitness industry may very well be a core business in the health care continuum, as the trends for the future will be disease management, demand management, self care, hospital wellness centers, and coordination of care.

It is possible that alternative approaches to medical care will also be an option for the individual. Thus, the health educator in these clinical settings will need to have an understanding of both eastern and western philosophy. Modalities such as massage therapy, acupuncture, aroma therapy, reflexology, and meditation will need to be among the repertoire of services offered by the health care educator.

The paradigm shift that is happening in health care comes from a change in focus on disease and illness treatment to a focus on wellness and prevention. The medical care model is shifting to a model based on recognizing the responsibility of an individual to develop a lifestyle that will balance mind, body, and spirit. With an increase in the use of various approaches to help people maintain their health, the health care educators will need to broaden their approach and to focus on coordination of these modalities. Hospitals will be opening "holistic centers," which should offer new opportunities for the health promotion/ health education professional as well. Increasingly, the future role of hospitals will include a prevention perspective and service. This was once considered out of the medical care mainstream, but is now emerging as a major component in a capitated system, as more people turn to hospital wellness centers for aerobics, stress management, swimming and other wellness enhancing activities.

In conclusion, hospitals will be involved by making available holistic health centers that focus on facilitation of healing and other alternative approaches to wellness. Managed care will continue to be a part of the integration of services as new revenue sources are explored. The health care educator of the future who wants to be a part of a hospital system will need to expand their learning horizons and develop expertise in both the medical and holistic approaches to health care.

The Evolution of a Profession: A Perspective From the Academic Setting

John Sciacca, M.P.H., Ph.D., C.H.E.S

As the 21st century rapidly approaches, it is fitting to reflect upon the past and present of health education* and contemplate its future. First, some of the major characteristics of the profession as it evolved in the 1970's will be reviewed. This will be followed by a consideration of the present status of the profession. The article in this issue entitled "Health Education in the 21st Century: An Outlook From the Academic Setting," will present a discussion of the future of health education. I hope my views will promote further thought and dialogue regarding what the profession can expect and how it can best prepare for the 21st century. Although the focus will relate primarily to the academic setting, some views and observations may well apply to all settings of practice.

The State of Health Education in the 1970's

After graduating from a master's degree program of study in community health education in 1975, I began my first full-time position as a health education specialist. I found it frustrating that, after much effort in completing a professional preparation program in health education, people with no formal training in the field were calling themselves health educators. I recall meeting a health educator from a health department who had his formal training in "religion." I also remember calling an administrator at a large hospital to learn if any health educators were on the staff. I was inquiring about establishing internships for health education students. After being referred to the continuing medical education office, I called back to try again.

In obvious exasperation the administrator said, "We have 300 health educators here! We are all health educators...who do you want to talk with!" It was also frustrating that few people I encountered knew what a health educator was or understood what one did. I recall numerous times introducing myself as a health educator and being met with blank stares and follow-ups such as "What is a health educator?" "What does a health educator do?" or a simple, "You're a what?" In all honesty, I wasn't entirely sure what it was that I, as a health education specialist, was supposed to be doing.

It was during this period in the 1970's that the Society for Public Health Education (SOPHE) report: "Guidelines for the Preparation and Practice of Professional Health Educators" was published. Helen Cleary, in her historical account of the credentialing of health educators, stated that it was this report, along with visits to various SOPHE chapters (as President-elect of SOPHE), that persuaded her that the field of health education was in desperate need of guidelines for preparation and practice. She states:

> "What I found in my travels was a profession in disarray. Many, many health educators could neither define themselves nor their role. It was clear that the preparation of most was so varied that there was no common core. There was no professional identity, no sense of a profession." (Cleary, 1995, p.2).

As I, too, discovered, there were no generally accepted criteria for what constituted a professional preparation program in health education, nor was there a generally accepted definition of health education. Program content varied widely and some programs were staffed by faculty prepared in disciplines other than health education.

In 1978, the Workshop on Commonalities and Differences in the Preparation and Practice of Community, Patient, and School Health Educators was held in Bethesda, MD to analyze the commonalities and differences that existed in the preparation of health educators, and to determine the feasibility of developing guidelines for professional preparation (National Commission for Health Education Credentialing, Inc. [NCHEC] 1998). The workshop planning committee was transformed into the National Task Force on the Preparation and Practice of Health Educators and work was begun to develop guidelines for professional preparation.

Cleary (1995) has thoroughly described the efforts to unify the profession and the challenges encountered in attempting to do so. For example, in 1981, a national conference for academicians from institutions preparing health educators was held in Birmingham, Alabama, to discuss a defined role for health educators and a curricular framework for the professional preparation of health educators. Many of the 238 academicians present were not pleased with the attempt to define and organize the profession. Although professional

* *The terms "health education" and "health promotion" are closely related and have been sometimes used interchangeably. Since the field developed under the name of "health education" and since that term is used in the national credential (Certified Health Education Specialist), "health education" will be used in this paper to denote our professional activities.*

preparation programs were certainly attempting to prepare competent health educators, there was no unifying philosophy of what constituted a qualified health education professional.

A 1982 survey of professional preparation programs documented that there was no uniformity in the curricula of health education professional preparation programs. In addition, dramatic differences were seen among faculty in the perception of the role of a health educator. Some academic programs were based on the philosophy that health educators should be experts in health and disease content, while others were based on the belief that health educators should be specialists in "process" with minimum knowledge of health and disease issues. Still others based their curriculum on the belief that health educators should be social activists whose total function is social change (e.g., to work for social improvements through mobilizing local communities, organizing strikes, and teaching people political skills). Surprisingly, some faculty fought the effort to unify the profession. For example, when in 1987 a credentialing system was about to begin, a number of health educators from the "social activist" philosophy did not want credentialing, and organized a group to try to force a moratorium on the organization of the NCHEC (Overbo and Williamson, 1990).

Nevertheless, through the efforts of many concerned and dedicated health education professionals and organizations, sufficient professional solidarity resulted in a general consensus concerning professional preparation and practice, and in greater credibility for the profession.

The Present

As a result of the work of visionary leaders and dedicated health professionals, a number of accomplishments have been realized. These accomplishments include the establishment of The President's Committee on Health Education in 1973, which helped to increase the visibility of the profession. The formation of the Coalition of National Health Education Organizations in the 1970's brought organizations together to work for the collective good of the profession. Furthermore, guidelines for professional preparation programs in school health were provided by the development of the National Health Education Standards: Achieving Health Literacy (Joint Committee on National Health Education Standards, 1995). In addition, the Arkansas Health Educator Practice Act, which requires that persons who practice health education in Arkansas hold Certified Health Education Specialist (CHES) certification (with a few exceptions during the first 2 years), was signed into law in April of 1997 (NCHEC,1997). This action set a precedent for similar legislation in other states. In October, 1997, the job category "health educator" was designated as an occupation within the U. S. Bureau of Health Professions (Auld, 1997). This designation recognizes health education as a health profession and places it in a more equal position with other allied health professions.

A major transition point for the profession was the effort that led to credentialing of health educators. The process that led to credentialing for health educators is well-described in The Credentialing of Health Educators: An American Experience (NCHEC, 1998) and in Helen Cleary's The Credentialing of Health Educators: An Historical Account 1970-1990 (Cleary, 1995).

By Spring 1998, nearly 6,000 individuals had obtained CHES certification, and 111 CHES examination testing sites had been established in the U. S. with the first permanent foreign site established in Taiwan, ROC. Job announcements for health promotion/health education positions have increasingly stated a preference, if not a requirement, for CHES certification.

The characteristics of professional preparation programs have also changed. A Framework for the Development of Competency-based Curricula for Entry Level Health Educators (National Task Force on the Preparation and Practice of Health Educators, Inc., 1985) for the preparation of professional health educators has been developed and many professional preparation programs have revised their curricula in accordance with these defined roles and responsibilities. This consensus of what constitutes appropriate professional preparation has changed academic programs.

Presently, there are many professional preparation programs for health educators at the baccalaureate, masters, and doctoral levels. The 1997 edition of the American Association for Health Education's Directory of Institutions Offering Undergraduate and Graduate Degree Programs in Health Education lists 215 institutions which offer degrees in health education. The Directory also delineates schools and programs in health education which have received (a) American Association for Health Education/National Council for the Accreditation of Teacher Education (AAHE/NCATE) accreditation, (b) Council on Education in Public Health (CEPH) accreditation (CEPH accredits schools of public health and MPH degree programs in community health education which are not in a school of public health, among other health programs), and (c) SOPHE/AAHE Baccalaureate Program Approval Committee approved undergraduate programs in health education. Interestingly, the majority of institutions offering degrees in health education have not received ANY such approval or accreditation. Only 14 are identified as having received SOPHE/AAHE baccalaureate program approval and just 8 of the 215 are both approved and accredited. While health education professional preparation program accreditation and approval processes do exist, individual program approval/accreditation does not appear to have gained wide support. Despite the large number of professional preparation programs, relatively few students are graduating from approved and accredited programs. Although SOPHE advocates for hiring health educators who are either certified or graduated from approved/accredited programs, the profession seems to have placed a greater emphasis on individual

certification (than graduation from an approved/accredited program) as the primary means for verifying an individuals' preparation for practice and qualifications in the field of health education.

Remarkable progress has been made in terms of role clarification, yet some confusion still remains among the public, as well as other health professionals, concerning what a health educator is and does. Currently, a number of other health professionals also claim to be doing health education. For example, in a recent article titled: "The School Nurse As Health Educator," Bradley (1997) describes the role of school nurses which includes health education. Although various health professionals do engage in some form of providing patients, students, and the public with information about health, few employ in their professional practice the functions of professional health educators. Furthermore, the majority have not met national eligibility requirements to sit for the CHES examination (which includes academic coursework in health education) nor have they attained national certification as Certified Health Education Specialists.

Despite a growth of evidence on the effectiveness of health education (Glanz, Lewis & Rimer, 1997) and the progress that has been made in the profession, there have been some disappointments. There has been a lack of a commensurate increase in K-12 school health education programs. In many areas, school health education programs are deteriorating or nearly non-existent (Davis & Hensley, 1997; Iverson, 1997). Although recent initiatives, led by the Education Development Center, Inc. and the Centers for Disease Control and Prevention (Marx & Wooley, 1998), are focusing more attention on the need for and processes of establishing coordinated school health programs, this is clearly a direction that needs to be developed in the future.

The importance of effective health education is evident when one reflects on the present health problems of Americans. Health behaviors such as smoking, alcohol and other drug misuse/abuse, sedentary lifestyle, and poor nutrition continue as major risk factors for the leading causes of death, disease, and disability (U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1998). These conditions present an opportunity for the profession to effectuate a large positive public health impact and become firmly established as one of the most important health professions of the 21st century.

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Health Education in the 21st Century: An Outlook from the Academic Setting

John Sciacca, M.P.H.,Ph.D., C.H.E.S.

Health education may be evolving into one of the most important health professions of the 21st century. As it develops, however, the profession will be challenged by several difficult issues.

"Risk Behaviors/Protective Factors" Will Continue To Justify the Need for Health Education

Tobacco use, alcohol abuse, the use of illicit drugs, poor nutrition, and sedentary lifestyles (among other negative behaviors) will continue to be major concerns. Although it is highly conceivable that, as a result of health education efforts, rates of these risk factors for disease will be reduced and the proportion of Americans who engage in protective behaviors will increase, millions of Americans will continue to engage in harmful behaviors. The need for academic programs to prepare students who will effectively address preventable public health problems will continue.

A Distinct Profession That Collaborates With Other Professions

The 21st century will see health education looking down two paths: one heads in the direction of shaping and cementing itself into a distinct profession with its own unique theories, models and training program, while the other leads toward an interdisciplinary approach to professional preparation and practice.

The art and science of health promotion and disease prevention (HPDP) is interdisciplinary and professions other than health education will continue to be involved in such efforts. Interdisciplinary collaborations may benefit the profession and result in more effective interventions and stronger academic programs. The interdisciplinary approach to professional preparation would require health education faculty to collaborate with professionals from other HPDP professions. Inter-departmental cross-listing of selected courses and inter-disciplinary team-taught courses, for example, would be a strategy to help establish stronger relationships with colleagues from other HPDP disciplines, provide students with new perspectives, and stretch program resources. Health education can learn from other HPDP disciplines and collaborative efforts could lead to more effective research projects, interventions, and professional preparation.

At the same time, health education is a unique profession. It will continue to be important for colleges and universities to strengthen health education professional preparation programs by employing a faculty prepared in this discipline. Similarly, it will be important to focus teaching on the theories, models, and strategies students need to know to function as professional health educators. It's possible that these two paths will merge in the 21st century.

The efforts of other professions to develop HPDP-related national certifications will raise questions among students and professionals about who are actually health educators, how these new certifications differ from CHES certification, and which certification(s) is/are most worthwhile. Although the lines separating health education from other HPDP professions may at times be blurred, through health education organizations working closely together (e.g., the Coalition of National Health Education Organizations, USA [CNHEO), it is probable that the profession will become increasingly crystalized and even more distinguished from other HPDP-related professions [NCHEC and CNHEO, 1996].

Future Opportunities

The Pew Health Professions Commission report: Critical Challenges: Revitalizing the Health Professions for the Twenty-First Century (O,Neil, 1995) has projected difficult realities for a number of health professions and greater opportunities for others as America's health care system becomes less focused on treatment and more concerned with education, prevention, and care management. The Commission projects a surplus of 100,000 to 150,000 physicians, 40,000 pharmacists and 200,000 to 300,000 nurses, but an increase in demand for health promotion/disease prevention professionals. Several reasons explain why new opportunities for professional health educators will emerge.

National Health Care Reform

The issue of national health care reform and national health insurance will very likely resurface. When it does, no other group is better positioned than Certified Health Education Specialist [CHES] to seize the opportunities national health care reform will provide in the promotion of, and reimbursement for, health education, and disease prevention interventions. As more people understand that prevention of health problems is more humane and cost effective than focusing on treatment of problems, it is reasonable to expect that the shift in the nation's private and public health systems from

an emphasis in treatment to an emphasis in disease prevention and health promotion will accelerate. It is also reasonable to expect that national certification of providers of health education will be required for third party reimbursement.

The recent designation by the U.S. Bureau of Health Professions of health education as a health profession moves the profession closer to third party reimbursement and an increase in demand for health educators (Black, 1998). Third party reimbursement will help to open new opportunities for qualified health educators and will be one of the most significant events in the profession's history. With an increased emphasis on preventive services and referrals by health care providers to health education specialists, the profession will have a demand never before seen.

An Aging America

Approximately 77 million "baby boomers" are approaching their "golden years" (Gutner, 1998) and many older adults will have chronic, disabling conditions. It is likely that they also will have a strong interest in learning more about health. Some older adults are expected to enroll in college health courses to pursue a lifetime dream of obtaining a degree (Berman, 1998), pursue a special interest such as health promotion and disease prevention, or learn to more effectively serve others as a health-promoting volunteer. The number of older American college students will continue its growth trend and faculty will have to modify their teaching methods to be more effective with older students. Because of the growth in the number of older Americans, health education curricula will include content on aging issues (Shirreffs, 1997).

School Health Education

It is conceivable that the 21st century will be a period of growth in K-12 school health education. With growing recognition of the importance of efforts to prevent such problems as teen pregnancy, sexually transmitted diseases, alcohol, tobacco and other drug use, and intentional and unintentional injuries, it is reasonable to expect that the number of K-12 schools providing coordinated school health programs will increase. When this occurs, interest in majoring in school health education also will increase.

The National Health Education Standards (Joint Committee on National Health Education Standards, 1995) will serve as a structure for school health curricula. Some academic programs will incorporate these standards into a new "integrated" curriculum.

Because many school districts are unable to employ separate teachers in both physical and health education, it has been proposed that academic programs offer an integrated curriculum to prepare students to be well-qualified to teach both areas (Davis and Hensley, 1997; Iverson, 1997). Some professional preparation programs will develop such an integrated curriculum. This will generate discussions among supporters and non-supporters, in both physical and school health education, about the value of combining these teacher-preparation programs.

Entrepreneurial Opportunities

As health educators' competencies become more recognized and valued by employers, commercial, for-profit entities may increasingly hire health educators to develop and implement prevention programs. More health educators may start their own health promotion companies. Since anyone can provide health information, and the dissemination of health information and advice via the Internet is expected to increase, it will be important for health educators to develop guidelines for consumers to evaluate health information and distinguish fact from quackery (Mail, 1998).

Tobacco Tax Funded Opportunities

If tobacco taxes continue to increase, large sums of monies will be available for tobacco prevention and cessation activities. Health educators will have to apply their advocacy and networking skills to secure those tobacco tax funds for health promotion purposes. They will not come automatically to health educators (Capwell, 1998). New tobacco prevention projects will provide unique opportunities for health educators. A growing interest in tobacco prevention should prompt more professional preparation programs to develop courses in tobacco prevention/cessation in order to prepare students for these opportunities.

Uniformed Services

With the downsized military, there have been increasing discussions about how to maintain and promote the health of the remaining troops. Health promotion in the uniformed services will be a fertile area for health education contributions in the 21st century (Mail, 1998).

More interest in Studying Health Education

An extensive variety and growing number of emerging opportunities, coupled with third party reimbursement for certified professionals, will have significant implications for academic programs. As the demand for certified health education specialists increases, interest in studying health education can be expected to grow. In support of this increased projected growth, a Society of Public Health Educators [SOPHE]/Johns Hopkins University School of Public Health expert panel has recently predicted an increase in the number of students pursuing graduate health education training (Auld, Gielen, & McDonald, 1998). When this occurs, students may then be selected from a larger applicant pool and academic programs may become increasingly discriminating in terms of who is accepted. Applications will likely be sub-

mitted and reviewed via computers, thus increasing the need for technologically literate faculty and staff.

Ethnic Diversity and Multi-cultural Perspectives

Another demographic change that has implications for professional preparation programs involves ethnic diversity and the need to prepare a workforce competent to meet the needs of a multi-cultural population. A national projection of the U.S. demographics suggests that as we enter the 21st century, ethnic minorities will account for one-third of the total population (Haynes, 1997). Furthermore, the proportion of ethnic minorities is predicted to grow close to 50% of the population by the first half of the 21st century (U.S. Bureau of the Census, 1993). Despite some gains in the past several years, ethnic minorities have historically been under-represented in the medical and allied health professions. Although current, accurate statistics are not available regarding the ethnicity of entering and graduating health education students, we know that Hispanic, Native American, and African American students are significantly underrepresented in college and university programs of study, in general, and in the allied health and medical professions, in particular (Gose, 1997; Magner, 1997; Burgess, 1997; Institute of Medicine, 1994; U.S. Dept. Of Health and Human Services, 1994). Effective strategies to recruit and retain students from the ethnic groups that comprise the population have been identified, yet not enough is being done and the pools of applicants and students remain under-represented.

As the proportion of ethnic minorities increases in the United States, professional preparation programs, as a whole, must place greater emphasis on two areas. First, the professional preparation program should place appropriate importance to multi-cultural perspectives, cultural sensitivity, and respect for other cultures and their customs. Second, the program should place a greater emphasis on recruitment and retention to graduation of individuals from ethnic groups underrepresented in the profession. If we are serious about preparing a diverse group of professionals to work with America's various ethnic groups and to practice in traditionally underserved areas, then academic programs must do a better job of recruiting and retaining individuals from ethnic minorities in undergraduate, masters, and doctoral programs and, ultimately, faculty positions. While the number of Ph. D.'s earned by ethnic minorities has grown, the proportion is still low. In 1996, for example, 86% of all U.S. recipients were white, 4.7% were African American, 3.4% were Hispanic and 0.7% were Native American (Magner, 1997). In 1995, 85% of all full time faculty and administrators were white non Hispanics (Schneider, 1998). Academic programs will have to do better than we have in terms of the diversity of both students and faculty.

Certification, Roles, Accreditation, Graduate Standards, and Ethics

Mandatory Certification to Practice

More states can be expected to enact legislation mandating certification in health education to practice as a health educator. Such legislation may become common throughout the U.S. If so, CHES certification would probably become the most commonly accepted indicator of qualification to practice as a health educator.

Revised Roles and Responsibilities for Entry-Level Professionals

A new role delineation project will be conducted and will result in updated core roles and responsibilities for entry level health educators. The CHES examination and professional preparation program curricula will, in turn, be modified to reflect the newly revised roles and responsibilities necessary to practice as a professional health educator

Program Approval/Accreditation

The profession will struggle with the question of whether stronger efforts should be made to promote program accreditation/approval, or if the emphasis should be placed on individual CHES certification as the primary designation of qualification as a health educator. Further investigations can be expected regarding the barriers to program accreditation/approval and whether identified barriers can be adequately addressed. It will be interesting to see how the accreditation/program approval question works out. It may evolve into a situation of academic programs choosing one (or more) of several kinds of health education accreditation/approvals. Or perhaps health education curricula will be relatively standardized based on what the profession thinks is important for students to learn and CHES certification will be viewed as sufficient indication that professional preparation standards have been met.

Graduate Level Standards

It is likely that an additional level of health education credentialing, beyond "entry level," will be established to distinguish higher levels of practice and specialization. This additional level of certification would be developed based on the recent "Standards for the Preparation of Graduate-Level Health Educators (SOPHE and AAHE,1997). When this occurs, academic programs offering masters and doctoral degrees will adopt a curriculum which provides coverage of these graduate level roles to ensure that graduates will be competent and prepared for certification.

Ethical Principles

Increased coverage of the proposed graduate competency relating to ethical principles will prompt reflection on the practical consequences of the profession's ethical codes in the practice of health education. The AAHE Code of Ethics (Association for the Advancement of Health Education, 1994) supports freedom of choice and the right of individuals to make informed decisions regarding their own health. The SOPHE Code of Ethics (Society Of Public Health Educators, 1993) also supports change by freedom of choice and self-determination, as long as these decisions pose no threat to the health of others. However, as Freudenberg, et al., (1995) have noted, most theories used in health education emphasize the role of the health educator in bringing about change, rather that the role of individuals in defining the goals of change and the methods to achieve those goals. If acceptable principles of practice include attempting to change the behavior of individuals who are initially uninterested, unwilling or unable (e.g., due to an addiction) to change their health behaviors, then are such methods unethical? Are interventions for alcoholics, strongly persuasive mass media campaigns, and attempts to influence and change a loved one's unhealthy behavior unethical? Is a person making a "free choice" to smoke if that person has been exposed to thousands of persuasive messages to smoke yet fewer and less persuasive messages to avoid smoking? Are higher pressure, persuasive approaches more acceptable in some settings or situations (e.g., alcohol education for persons convicted of DUI, smoking cessation interventions for a person recovering from a heart attack, education about HIV for a high-risk population)? When should the health educator stop trying to bring about change in someone who seemingly does not want to change? Can one justify highly persuasive approaches by arguing that people will just about always have a "free choice": they can either change their behavior or accept the consequences? If we define health to include psychological, environmental, and social dimensions, then can we justify more forceful interventions based on a threat to health in its broad definition?

The Coalition for National Health Education Organizations has recently developed a unified code of ethics which combines the SOPHE and AAHE codes. It will be interesting to see how the profession answers questions regarding the practical application of its ethical principles.

Research and Theories

Health educators will likely be held more accountable for their services, thus increasing the importance of preparing students with the skills needed to adequately apply theoretical constructs and demonstrate the effectiveness of interventions. Academic programs will be challenged with the task of convincing future professionals to utilize an appropriate theoretical framework in all health education interventions. With growing realization of the importance of behavior change theory, increased presentation and discussion of theories and their applications will need to be integrated into coursework. The presentation of theory should, perhaps, be more application oriented to better bridge the existing gap between theory and practice (Neiger, 1998). There may also be a need to place a greater emphasis on combining theories as appropriate for different situations (Capwell, 1998).

Despite the prevalence of theories, as the 20th century comes to an end, many health education interventions have not utilized a theoretical framework. Glanz, Lewis and Rimer, (1997) reviewed the use of theory in articles relevant to health promotion and education, published from mid-1992 to mid-1994, and found that although only 44.8% used one or more theories or models, 66 distinct theories and models were identified. If it is true that the profession has an abundance of behavior change theories available for use, yet a rather limited understanding of how well they work (Freudenberg, et al., 1995), especially for various cultural groups, then the application of theory to all interventions may be more useful than the development of new theories at this stage in the profession's development. With an increased emphasis on, and application of, theoretically driven interventions and program evaluations, some theories will be refined and the overall effectiveness of health education may be improved.

Technology

Professional preparation programs will be challenged by the continual evolvement of educational technologies. The expansion of the Internet, compressed digital interactive television, satellite teleconferencing, and Web-linked CD-ROM technology, among other advances, will challenge faculty to transform the way they teach. The popularity of distance education programs is increasing and many academic programs are developing distance education programs as a way of stretching program resources and attracting adults who want to go back to school (Brownson, 1998). For example, distance education students can now turn in assignments over the World Wide Web and interact with faculty via E-mail and the Internet. Furthermore, with interest in learning about health growing in the general population, distance education, including interactive instructional television, may be one of the more effective ways to educate both students and the general public. The growing importance of high-technology as a health education strategy will require restructuring courses to prepare students for future technology-intensive roles. Hands-on training in technology will be infused into the health education curricula of the 21st century and students will expect faculty to be at least as computer literate as they are. Health education faculty who have been resisting the pressure to learn and practice new technologies need to accept that these technologies are here to stay, become more high-tech literate, and change the way they teach their classes.

Conclusion

There have been significant accomplishments in the profession since the 1970s. A variety of events are unfolding which may help secure health education's position as one of the key health professions of the 21st century. Academic professionals may help the field develop by keeping updated on issues that have implications for professional preparation, by attending professional meetings, and by serving on national health education organization committees. Academic program faculty also may help by updating other faculty through regular communications with colleagues and updates at faculty meetings.

Merely reacting to change will not be sufficient for optimal development of the profession. Progressive academic programs will utilize the health educator responsibility, "planning effective health education programs," to prepare competent and marketable professionals. Developing, updating, and using a strategic plan will help programs to achieve a vision for the future that is consistent with the profession as a whole.

The advent of the 21st century will bring significant growth in the variety and number of professional opportunities for health educators who have met national standards. It is probable that health promotion and disease prevention will become a national health priority. The 21st century holds the prospect of increased recognition and demand for health educators. Altogether, the vision for health education is bright. Shaping health education's future will require continued thoughtful teamwork to ensure its place as one of the critically important health professions of the 21st century. This is an exciting and challenging time to be a health educator.

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Health Promotion Specialist Preparation in the 21st Century: The Challenge for Institutions of Higher Education

Roger W. Seehafer, Ph.D. & Gerald C. Hyner, Ph.D.

In the Beginning.....

The initiation of health promotion programs in academic settings has been closely linked with that of American business and industry. Facing alarming increases in the cost of medical care and health insurance, as well as having to pick up a higher percentage of the nation's health care bill, a number of corporate settings began serious inquiry and exploration of disease prevention and health promotion in the late 1970s. Negotiable benefits for employees were eroded and major financial strain placed on many businesses. Emerging research and epidemiologic studies also began to provide a clearer picture regarding the course of medical service cost increases and, more importantly, the role of potentially modifiable risk factors and their relationship to premature mortality and unnecessary morbidity.

Faculty in institutions of higher education observed these developments in worksite and related settings with more than idle curiosity and envisioned disease prevention programs with their curricular, professional training, and research implications. In particular, programs of health education and health education faculty were quick to identify with emerging worksite programs and the professional skills and competencies articulated by program providers. In fact, many health educators suggested (and many subscribe to the view even today) that "health promotion" was nothing more than another term for their own discipline. Indeed, even basic terminology and vocabulary in the 1970s was a challenge since terms such as: health promotion, disease prevention, health education, wholistic/holistic health, and wellness, among others, were used interchangeably and without distinction.

Meaning of Health and Other Terminology

In 1992, Michael V. Hayes published an influential and challenging paper on the epistemology of risk. He examined the disparate uses of the term "risk," the lack of conceptual coherence in the risk literature, and the implications for risk management and disease prevention. Nowhere are these vagaries better exemplified than in the contemporary definitions of health promotion. Hayes distinguishes between the definition offered by O'Donnell (1986) in the *American Journal of Health Promotion* which emphasizes lifestyle change, and the World Health Organization (1987)which acknowledges health and disease factors beyond the control of the individual. These subtle differences have profound implications for risk management, policy development, the provision of healthcare, and professional preparation. For example, if significant occupational risks are deemed unavoidable, and the primary determinants of health status are assumed to be susceptible to individual behavioral control, the potential for inactivity on the part of employers with regard to the provision of safe worksettings may be realized. Hayes (1992) acknowledged that singularly acceptable definitions are a challenge and that there is "...no single truth" (Page 406). Clearly, the widely varied uses of terms such as: risk, health promotion, and healthcare suggest the need for a continuing dialogue and careful examination of the epidemiologic evidence for the causes of disease. One might imagine health promotion specialists of the 21st Century as involved in crafting tobacco policy and antitobacco lobbying, as they currently are in providing smoking cessation interventions and tobacco avoidance education. If there is eventual agreement on a more expansive role for the profession, particularly if environmental and social determinants of health and risk are deemed appropriate for the mission of the health promotion specialist, future opportunities and challenges appear limitless.

Professional Preparation Programs and Higher Education

Disconcerting to traditional health educators was the emergence of professional preparation programs from disciplines such as sociology, psychology, counseling, and nursing, which also claimed academic and disciplinary ownership. As standards and guidelines regarding skills and competencies for professional development of health promotion specialists were non-existent, health education faculty and programs of health education that recognized the importance of other disciplines in the substantive contributions to health promotion were at a loss for curricular models to assist them in the design of meaningful undergraduate and graduate programs of study. Although research had delineated the role of personal lifestyle and health, the field lacked a substantive body of empirical research to provide a disciplinary identity or an agenda for curricular programming . In this author's (RS) experience, for example, attending a national health promotion conference in these early days included listening to a highly sophisticated and compelling research-based presentation on the nature and role of health promotion by one of the field's leading authorities, only to be solicited in the outer hallway by a commercial vendor purporting to provide the

same information via an on-the-spot hair sample analysis.

Problems related to the disciplinary identity crisis, disparate definitions of health related variable, absence of professional standards and guidelines, and the lack of an empirical research basis made it difficult for faculty or programs to persuade for the necessary courses, equipment, and, most importantly, faculty to design and implement programs of study specific to health promotion. Those who persisted were often met with administrative resistance and/or serious reservations. In other words, "if that's what you really want to do, go ahead and do it. But....." Those familiar with the nature of higher education would hardly be surprised. Change is generally resisted. Historically, higher education has been known to be more reactive than proactive in responding to societal and professional trends (Karch, 1998).

Resistance within academic communities might also have been related to the emerging departure from such traditional programs as school health education, or because the progenitors of the academic models were acting in response to external forces, such as business, industry or medical care providers. Although the specific reasons might remain unclear, those pioneering health promotion in academic settings learned early on what their counterparts in other settings had also learned. At the very time that health promotion was attempting to define itself, and what a health promotion specialist meant, the emerging professionals were constantly educating those around them, at all levels, what it was that health promotion meant to them....And they would re-educate their colleagues again.

Contemporary and Future Implications for Higher Education

Since those early days the prevalence as well as the development, and maturation of health promotion programs in academic settings has been significant. But in terms of meeting the ever-increasing and more sophisticated health promotion professional skills and competencies, institutions of higher education face major challenges if they are to be effective partners in advancing the field of health promotion on the national scene. At any level or within any setting, if there is to be successful health promotion programming, it will be the direct result of the professional leadership in place. The ability of the academic community to assume the responsibility in preparing such professional leadership is increasingly under question. This is a most important issue as the success of programs are clearly dependent upon the professionals that operate them, more than the result of facilities and funding. However, as indicated in a recent article directed at the training of health promotion professionals (Karch, 1998), currently most health promotion professionals do not come "from" the profession but rather "to" it from some other discipline or combination of disciplines. He further states:

> More specifically, many have migrated to the profession from somewhat related disciplines (e.g. exercise science, public health, health education, physical education, and even medicine and psychology). This migration has occurred primarily because most institutions of higher education throughout the world have not provided clearly defined professional paths through undergraduate and graduate studies leading to the health promotion profession. Further, much of the professional guidance and industry standards to date have not come from the universities but rather from professional associations. Moreover, even the industry's professional journals have risen from scholars outside the faculties of universities. (p.1)

We believe that if professional career opportunities and the advancement of healthy living is to continue into the 21st Century, institutions of higher education must focus on establishing a clearly defined teaching, research, and service agenda that will lead to the education and development of health promotion professionals "from" the discipline. Toward that end, this article identifies some of the issues and activities along the traditional teaching, scholarship, and service missions in higher education that might lead to a more effective partner on the professional scene. Three such programmatic issues and activities include the necessity to be more highly interdisciplinary in nature, the acquisition of a focused theme or identity specific to a given college or university's health promotion program, and a more intimately coordinated approach with practitioners and professionals in the field.

Teaching

Programs preparing health promotion professionals for the 21st Century will need to become increasingly interdisciplinary, focused, and interactive with professionals in other settings.

Health education programs, which early on identified themselves as the legitimate foundation field for health promotion, were clearly challenged by authors such as Green and Johnson (1984) and Saunders (1988) to go beyond traditional information-dissemination strategies, as the combination of educational, organizational, economic, and environmental supports for behavior conducive to health emerged as a conceptual model for the discipline. By 1986, one compilation of a partial list of disciplines possibly contributing to health promotion included 39 different fields. The large number of disciplines that the field of health promotion currently spans clearly indicates the necessity of highly interdisciplinary curricula and programs of professional development.

Such interdisciplinary programs will necessitate curricular creativity and synthesis that goes well beyond much of the academic cosmetic activity that has occurred to date. These have included the numerous name changes such as "health promotion" and "kinesiology" over "health education" and "physical education" respectively in order to be fashionable or more academically respectable, when the lists of courses for these "new" majors and course content itself demon-

strated little or no substantive changes. "Interdisciplinary" programs also appear to have followed this model. For example, a recent applicant for graduate school who had just completed an undergraduate degree in "Physical Education and Health" had only one health course over the entire undergraduate plan of studies, which apparently justified its interdisciplinary title. Programs in the future will need to be legitimately and truly interdisciplinary by combining the contributions and course work of such disciplines as health education, exercise and fitness, nutrition, communications computer technology, management and marketing, economics, etc..

But how interdisciplinary can undergraduate and graduate programs of professional preparation realistically manage to be? Already programs that have made substantial curricular and programmatic revisions are realizing that it is impossible to encompass all the skills and competencies suggested by the historical and contemporary cross puzzle of contributing fields and disciplines, the numerous existing and emerging guidelines for professional preparation, and the evolving nature of health promotion itself. Therefore, it may very well be that programs in higher education will not attempt to cover all of the possible disciplinary theory and content, but will begin to identify particular areas of emphasis or excellence with which they want to be identified, such as preparation for worksite settings, the use and application of educational technologies, public health promotion or health promotion for large populations, and international/global health promotion policies and programs, as possible examples.

We believe the successful transition to more interdisciplinary, as well as more focused academic programs of preparation for the 21st Century, will require yet another characteristic: a highly interactive relationship with professionals beyond the university setting. Are faculties and programs prepared to have their courses, curricula, and graduates directly influenced by professionals in the field? Faculties are notorious for advocating change as long as it does not affect their courses or their curricula. Resistance to modifying "our" courses and "our" program is almost to be expected, especially when such change is initiated from beyond one's own department or, worse yet, from beyond academia. Faculties of successful programs of preparation for the future will need to transcend their personal histories (when I was in college I took these courses...), and natural predisposition to protect academic egos and disciplinary turf. Faculties will also be required to admit to some of their prior isolationist existence and disciplinary tunnel vision limitations by reaching out to the many professionals and practitioners in the field who have invaluable insights and contributions that need to be integrated into the classroom and curriculum.

Research

As with teaching, researchers in health promotion will need to accommodate a more interdisciplinary, focused, and professional-oriented agenda. To develop research initiatives, teams of interdisciplinary scholars will be more effective than those of individual faculty or discipline-specific paths of inquiry. Also, researchers must of necessity identify focused, achievable research objectives. Unless this is done, the scholarly endeavors and resultant empirical bases needed by the field will result in little more than scurrying about on the broad surfaces of health promotion, and prevent their reaching into the critical depths of health risks, lifestyle behaviors, socio-environmental factors, prevention of premature mortality and unnecessary morbidity and the achieving of a higher quality of healthy living.

Finally, researchers must coordinate their research agendas more closely with the needs of the practitioner and professional in the field. We feel that partners of higher education avoid the continued surveying/documentation of the nature and severity of the problem. Worksite and related settings have known this and recognized it long ago. In fact, their realization of the problems related to unhealthy lifestyles is what caused them to initiate programs in the first place. What is not needed by our partners in the field are continued advancement of additional theoretical models of behavior change that provide interesting debate and discussion for the academic, but remain unproven in their application to the professional field. What is needed of the research community are the models, strategies, and interventions that contribute to the most critical challenge to the practitioner in the field: accountability. Can we provide the outcomes as a result of our program efforts that we feel and advertise we can do? In view of the overwhelming costs and required expertise in experimental design and implementation, evaluation of health promotion programs to document outcomes cannot be expected to be done by practitioners alone. The evaluation of program outcomes by integrating the issues, problems, and populations into the research agendas of academia appear to be an absolute "win-win" situation.

Service

Although often considered as less important than scholarship or teaching in the academic scheme of things, service-related activities offer important benefits to institutions of higher education as well as their counterparts in the field. For those programs that have explored or utilized student internship, practicum or co-op activities, at both the undergraduate and graduate levels, the benefits to students (invaluable experience, skills acquisition, professional competency development, resume' enhancement, networking and job placement opportunities) and professional setting (invaluable staffing and human resources) are oftentimes immeasurable. Those programs that have included "professional in the classroom" opportunities have likewise enhanced the experiences and level of professional preparation of their students. Finally, those programs or faculty that

have entered into service contractual arrangements to provide expertise or on-site services have discovered an attractive and viable source of supplementing severely constrained financial budgets.

Standards of Ethical Practice

Allegrante and Sloan (1986) published an important editorial in *Preventive Medicine* which has implications for the contemporary and future practice of health promotion. Their paper examined the ethical dilemma faced by the workplace practitioner, yet the same challenges surely exist in other professional settings as well. Their expressed concerns are as timely and relevant today as they were more than a decade ago. As the health promotion specialist strives to reinforce healthier lifestyles and the modification of risky behaviors, the potential for victim-blaming, participant coercion, and loss of privacy will remain an important issue in the 21st Century. The authors caution practitioners to carefully consider the implications of an over-enthusiastic emphasis on the individual's culpability for illness. They suggest a need for an expanded approach to health promotion that includes recognition of the political, economic, and social influences on health status. The academic preparation of health promotion specialists must provide the opportunity for discussion of the ethical dilemmas that the professional will likely face in their practice. Allegrante and Sloan (1986) ask, "...how can we maintain our sense of professional integrity and our own moral hygiene under such circumstances?"(Page 314). Academic programs of the future will serve as the ideal venue for discourse on ethical issues, and in the generation, articulation, and protection of ethical standards of practice for health promotion specialists.

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The Importance of Prevention Research*

John R. Seffrin

For much of the history of modern medicine and public health, our nation's research efforts on chronic dieseases have primarily focused on a curative approach. Rather than seeking the most effective methods to prevent chronic disease through social regulation and behavioral change, most research has sought to develop biomedical interventions. This approach has been driven in part by the success of treatments developed for many communicable diseases and, perhaps even more so, by the public's overwhelmingly positive response to these breakthroughs. Indeed, with the discovery of powerful antibiotics and effective vaccines designed to treat or prevent a wide variety of communicable diseases, public expectations for "magic bullet" cures have increased dramatically. For many, such cures are the obvious an overriding goal of all medical research. Nothing less will do. While the public may appreciate research that helps improve health and prevent disease, what they really want are simple, painless, and effective cures.

Not surprisingly, as the public's expectations have grown, so too have their demands for unlikely results. For instance, the American Cancer Society's National Board of Directors recently set ambitious new goals for reducing cancer incidence and mortality rates. Working with others, the Society hopes to reduce the cancer incidence rate by 25 percent and the cancer mortality rate by 50 percent by the year 2015. Ask any cancer researcher about these goals and he or she will whistle in disbelief. The general public, however, is less impressed. When several focus groups were asked what they thought of the Society's 2015 goals, their response was just the opposite. For many, the goals were too little, too late. By 2015, the respondents wanted a cure for all cancer. In fact, they want a cure today.

Unfortunately, successful cures are few and far between. Medical research, like all other research, is incremental. Slowly, bit by bit, we inch our way forward. Yesterday's breakthrough is often tomorrow's dead end. Occasionally, a "magic bullet" is discovered, and for this we are grateful, but more often than not new treatments simply ameliorate conditions—deadly diseases like AIDS become chronic ones, and new medicines replace old standbys. Yet despite this slow and often frustrating progress, we continue to search for "the cure" and sometimes ignore other promising avenues to resolve personal and public health problems.

The Role of Prevention

It is time to try another course. While it would be foolish to abandon research into treatment and cures, we must begin to focus more of our efforts and resources on prevention. Prevention is the real key to reducing unneccessary morbidity and mortality, and prevention research is essential to understanding which interventions, policies and behavior changes will lead to more healthful lives for all.

Why is prevention research so important to our country today? Consider, for example, the following startling statistics about our nation's youth from the Children's Defense Fund (CDF website):

Every day in America . . .
1 mother dies in childbirth
3 people under the age of 25 die from AIDS
6 children and youths commit suicide
16 children and youths are killed by firearms
36 children and youths die from accidents
81 babies die (overall)
144 babies are born at very low birth weight
443 babies are born to mothers who received late or no prenatal care
2,556 babies are born into poverty
3,000 youths become tobacco addicts
3,436 babies are born to unmarried mothers

These figures are staggering. That we are still struggling, today, at the end of the 20th century, with issues such as these is almost beyond comprehension. We as a nation must find a way to provide **all** our children with a safe and stable environment, one that will allow them to realize and achieve their full potential. Of course, there are no quick fixes for many of these problems, but today we are better prepared to address these issues than ever before. We now have a growing body of knowledge revealing what seems to be effective—what seems to work and what doesn't.

There was a time in the not too distant past when the public health community had very little knowledge about how to prevent chronic disease. Today that has changed. We now know, for example, that smoking is the most preventable cause of death in our society and that a diet high in fruits and vegetables, regular exercise, and weight control all help prevent cancer and heart disease. In fact, as we stand on the brink of the new millennium, our potential to prevent disease and save lives and to improve the quality of life for all Americans is greater than at any other time in recorded history. Moreover, the arguments to move forward and do so are truly compelling, because prevention not only addresses our core human values and established national priorities, it can be economically advantageous as well. We now have the way — but we must generate the will — to do what is right!

Prevention is the key. If one is not convinced, consider the following examples of prevention triumphs in medicine and public health: The eradication of the great plagues, polio, and smallpox; the reduction of dental caries; the development and use of passive restraints in automobiles; and the discovery of chemo-preventive agents such as aspirin for cardiovascular disease. Indeed, it is this author's contention that no major pandemic, virtually no major public health problem, has ever been brought under control by any means other than prevention.

Today, the 10 leading causes of death in the US are more preventable than curable. Michael McGinnis and Bill Foege underscore this truth in their review of the actual causes of death in the U.S. at the end of the 20th Century. The following table summarizes their findings:

Actual Causes of All U.S. Deaths (McGinnis, 1993)

Cause	Percent
Tobacco	19%
Diet/activity patterns	14%
Alcohol	5%
Microbial agents	4%
Toxic agents	3%
Firearms	2%
Sexual behavior	1%
Motor vehicles	1%
Illicit use of drugs	<1%

But how do we take this knowledge and enact changes that will truly improve public health? Unfortunately, in far too many cases, we still don't know. However, the first step seems obvious, we must do much more prevention and intervention research.

The Importance of Research

Our nation's health goals are laudatory, well thought out and, indeed, achievable. But they won't be reached if we don't redouble our nation's commitment to prevention research — broadly defined as that systematic inquiry that leads to knowledge and understanding of how to intervene and bridge the gap between what is and what could be with respect to our nation's public health.

Biomedical research, as we know it today, has been a marvelous asset in science and discovery and a true success story with respect to our basic understanding of human pathology, molecular biology and human cell behavior. Since the early 1950's, however, biomedical research has been an overall failure in realizing its true potential to improve public health. This failure during the second-half of the 20th Century is largely due to an incomplete national health research program. A program that has stopped short of supporting "the right stuff" — the prevention research necessary to bridge the gap between basic understanding and applying this understanding to and for the benefit of real people in a real world. The critical goal in our nation's health research program must be to change outcomes. We must seek knowledge not for knowledge's sake alone, but rather to benefit the human condition and thereby help assure the future vitality of our nation.

Three brief examples serve to illustrate just how critical prevention research is to meeting our nation's health goals and to improving the quality of life for all:

Tobacco (primary prevention). During the past year, our federal government seriously considered comprehensive legislation to protect children from tobacco and to hold the tobacco industry accountable. Indeed, for the first time ever, the U.S. Senate debated on its floor a comprehensive tobacco control bill for a full month. Unfortunately, that's as far as the bill ever got. There are a number of reasons no bill was passed, including, of course, Big Tobacco's power and influence. Nevertheless, another reason no legislation passed was due to the fact that the public health community couldn't assure policy makers that we knew how to keep kids tobacco free. If we had invested heavily in tobacco-use prevention research from the 1964 Surgeon General's Report onward, we would likely have discovered by now just what interventions are necessary to keep kids from getting addicted to tobacco. If we don't learn from this powerful lesson, we are probably doomed to repeat the same mistake again.

Colon cancer (secondary prevention). Colon cancer is the number two cause of cancer deaths in both men and women, accounting for some 57 thousand deaths per year. We now know that regular screening can save 50-60% of the lives being lost annually to colon cancer, a disease which usually develops from benign adenomas over time. Unfortunately, as of this writing, we have no standardized nationwide colon cancer screening program, and we have not done the prevention research necessary to understand how to get people to comply with proven colon cancer check-up guidelines. No knowledgeable public health professional today denies that we know what needs to happen to save lives, but no one knows how to get it done.

Pain relief (tertiary prevention). Early in this century, cancer became the disease that Americans feared most, and for good reason. In the early decades of this century, any serious diagnosis of cancer was a virtual death sentence, only to be preceded by a painful debilitating decline before death. Today, many cancers can be cured, but for those who die from cancer, many still suffer needlessly in pain. Even though we have had pain control know-how for more than a decade, as well as the tools to control most pain, a 1994 study found that 42% of a group of cancer patients received inadequate pain treatment and a 1993 survey found that 85% of physicians who provided care to cancer patients in the last 6 months provided inadequate pain relief. (Foley, 1996) What is worse, 26% of patients in pain, living in nursing homes in America, get no pain relief at all. (Bernabei, 1998) While this constitutes a moral outrage, we must be honest and admit that insufficient research has been done to show us how to

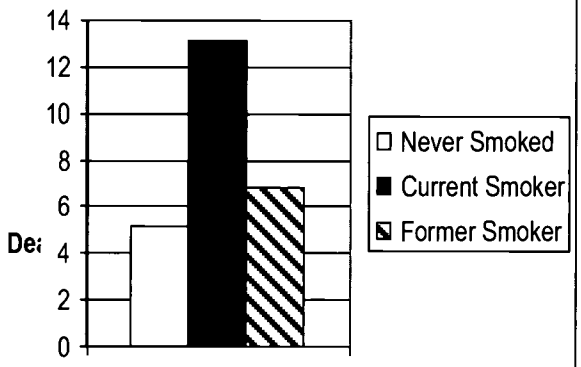
get "the system" to respond appropriately.

While the above three examples are all quite different, they represent very real issues that one form or another of prevention research, followed by action, could resolve. Moreover, if resolved, the public health and quality of life in America would be improved dramatically.

Prevention Through Lifestyle Change

We now have many — perhaps most — of the answers needed to change dramatically the health of people and to achieve our nation's health goals as outlined in Healthy People, and to realize the CDC's mission of healthy people in a healthy world. Consider, for example, the latest findings from the American Cancer Society's Cancer Prevention Study II (CPS II), which suggest that relatively modest lifestyle changes can significantly reduce disease and increase life expectancy. Tobacco use is an obvious case in point.

Figure 1. Probability of Dying between Ages 35-69 by Smoking Status -- Wome



As can be seen in figure 1, a woman who smokes is more than twice as likely to die before her 70th birthday than a woman who has never smoked. What is so remarkable about this finding is not the fact that smoking affects mortality, but the magnitude with which it does. Again and again, tobacco has proven to be an incredibly efficient killer. The findings are even more dramatic for men (Figure 2).

Please also note the stair-step phenomenon in both cases. Never having smoked is best, but quitting certainly helps. When smokers quit, their risk decreases slowly but significantly and over time can return to near normal levels. In fact, to date, smoking cessation is the only behavior change in adulthood that has proven to reduce the risk of premature death.

When it comes to exercise, we see another interesting pattern. Heavy exercise is clearly associated with the lowest mortality risk for both men and women.

Again, the findings tend to confirm earlier suspicions and are particularly significant for men (Figure 4). Men who do not

Figure 2. Probability of Dying betweer Ages 35-69 by Smoking Status -- Men

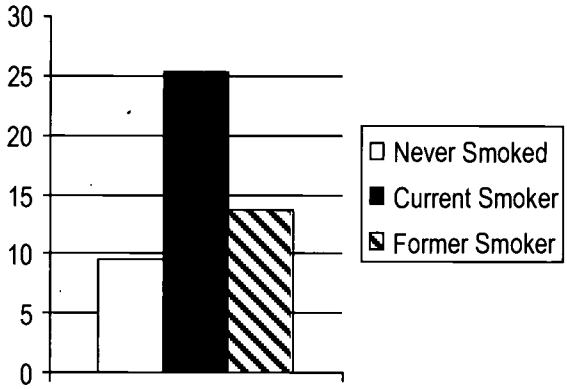


Figure 3. Probability of Dying between Ages 35-69 by Level of Exercise -- Womer

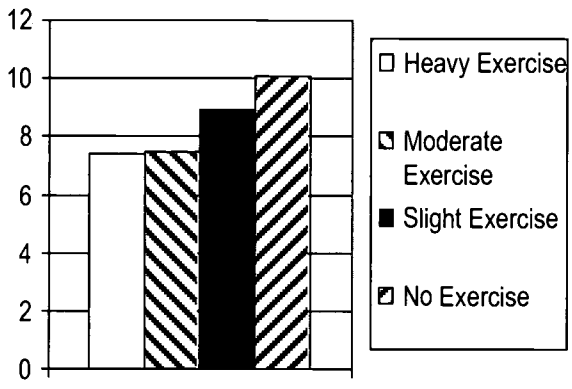


Figure 4. Probability of Dying between Ages 35-69 by Level of Exercise -- Men

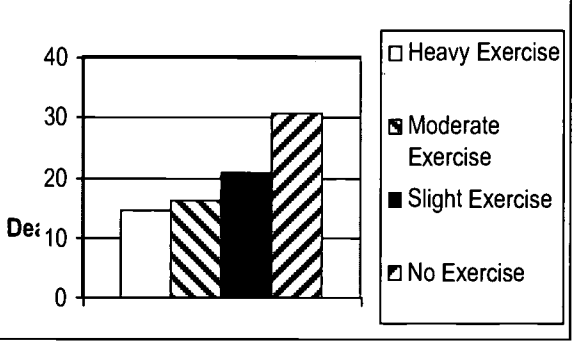


Figure 5. Probability of Dying between Ages 35-69 by Smoking Status and Exercise -- Women

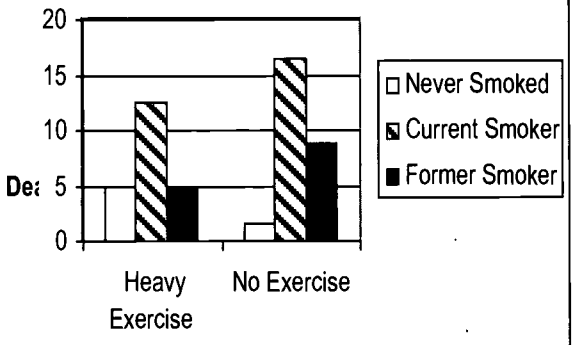
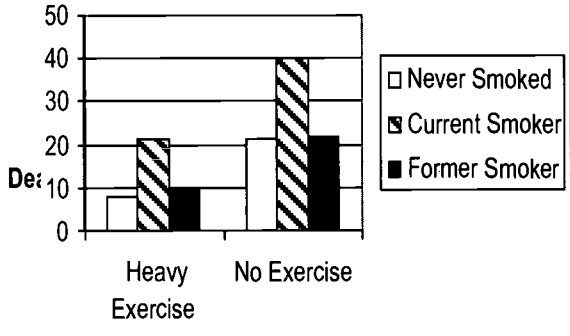


Figure 6. Probability of Dying between Ages 35-69 by Smoking Status and Exercise -- Men



exercise are more than twice as likely to die in mid-life. In fact, not exercising at all can increase a man's chances of dying prematurely to more than one in three, assuming the relation is causal. This is a rather shocking statistic and should serve as a wake up call to all those who believe physical activity is optional for good health.

Perhaps our most important finding was that smoking and exercise, when taken together without regard for any other behaviors yield, the most significant and dramatic differences in the rate of premature mortality.

The results are clear and unequivocal. As a woman, if you never smoke and you exercise regularly, you are only *one-third* as likely to die in mid-life as your smoking, non-exercisizing counterpart (Figure 5).

The findings are even more remarkable for men. A smoking male who does not exercise has nearly a 40% chance of dying in mid-life. His non-smoking and physically fit counterpart's risk is only 8%.

In addition to the effects of tobacco and exercise, our CPS II data reveal that maintaining a healthy weight and consuming a diet high in fruits and vegetables (at least five servings a day) also help to reduce the risk of disease and early death. These facts are so important that we have made alterations in our institutions research programs, and are now putting much more emphasis on prevention, psychosocial and behavioral research.

The decision to invest greatly in prevention research is more than just a matter of priority setting among competing needs, it is for our nation a moral imperative. Remember Hubert H. Humphrey's great words: "The moral test of government is how it treats those who are in the dawn of life — the children; those who are in the twilight of life — the aged; and those who are in the shadows of life — the sick, the needy and the handicapped." (Humphrey, 1977) Today, we are the trustees of knowledge and resources that, if properly applied, will save lives, promote health and further much of what is the American Dream. In a very real sense, prevention *is* "the cure" for many of our immedicable woes, and prevention research is the mechanism by which sound theory can be translated into successful programs that really work.

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* *This article has been adapted from a speech given by the author at the Congressional briefing on prevention research sponsored by the American College of Preventive Medicine, the Association of Schools of Public Health, and Partnership for Prevention, June 4, 1998. The CPSII data above also appeared in Premises, Promises, and Potential Payoffs of Responsible Health Education. Journal of Health Education, 28(5), 198-307.*

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The Evolution of Worksite Health Promotion: Where Have We Been and Where Are We Going?

Mark G. Wilson, HSD

Introduction

You can observe a lot by watching.
Yogi Berra

No other setting has witnessed the rapid growth in health promotion programs in the past two decades that the worksite setting has experienced. Twenty years ago there was no mention of the term "worksite health promotion" in the professional literature. Recently, surveys have indicated that 81% of worksites with 50 or more employees and 24% of small worksites (15 to 99 employees) are offering health promotion activities to their employees (Department of Health and Human Services, 1992; Wilson, DeJoy, Jorgensen, and Crump, under review). Worksite health promotion programs have progressed from activities designed to do nothing more than improve employee morale to multi-component programs designed to affect major health problems with multiplicative etiology, such as cardiovascular disease and cancer (DeJoy and Wilson, 1995). What is amazing is this rapid growth has occurred in an environment that was largely unsure of the nature of health promotion and the role it was supposed to play in the organization.

In this paper, I would like to share my observations on the evolution and future direction of worksite health promotion. As I have watched worksite health promotion evolve, it has gone through a series of stages that I will refer to as the infancy, growth, and maturation stages. The infancy stage was manifested by the birth of worksite health promotion and the attempt to develop an understanding of itself and its role within the organization. The growth stage was characterized by the rapid increase in the prevalence and complexity of worksite health promotion. This stage describes the current status of worksite health promotion. And finally, the maturation stage embodies the sophistication of worksite health promotion as it integrates itself into the fabric of the organization and consolidates with public health and managed care. This is the future direction of worksite health promotion.

Infancy of Worksite Health Promotion

Remember always to be grateful for the millions of people everywhere whose despicable habits make health education necessary.
Mohan Singh

Although the proliferation of worksite health promotion programs is a recent phenomena, evidence exists of health promotion programs being offered at the worksite as early as the1800's. In the 1850's Pullman Company started offering a stretching and exercise program for its employees and in the 1890's Campbell Soup Company banned smoking from the worksite. Both measures were undertaken for reasons other than health promotion as the health-related benefits of both activities were largely unknown at the time. However, one can only assume that both endeavors ultimately impacted the health of employees as fewer employees suffered muscular injuries on the job and daily cigarette consumption decreased.

These types of activities reflected early worksite health promotion efforts which consisted of programs offered for reasons unrelated to health (O'Donnell and Ainsworth, 1984). Companies have supported bowling leagues and softball teams for years in an attempt to improve employee morale and community relations and not necessarily impact physical fitness. Most onsite programs started in the 1960's were fitness facilities that were originally viewed as a company perk for executives or managers and usually were not open to the general employee population. Remember, this was a time when the economy was booming, unemployment was low, health care was relatively cheap, and businesses could sell almost anything they produced. Many of the incentives currently driving businesses' interest in health promotion and disease prevention did not exist.

Most of the health promotion-related activities that were started for other purposes were organized and implemented by individuals with little formal health promotion or health education training. They might have come out of the human resources, training, occupational safety and health, and/or medical departments all with an interest in health or wellness, but most with no formal training. Consequently, programs or activities tended not to be based on a health-related conceptual or theoretical framework were not grounded in behavior change research, and were not evaluated to determine their impact or outcome. Although these early worksite practitioners were hard working and meant well, their "learning on the job" slowed the evolution of the worksite health promotion profession.

As worksite programs became more common, programs started to be offered that were characterized by a focus on a single intervention, designed to impact a single risk factor or behavior, and/or targeted toward one specific group

(O'Donnell and Ainsworth, 1984). The worksite health promotion literature is replete with evaluations of these type of interventions (Wilson, Holman, and Hammock, 1996; Wilson, 1996). These were the smoking cessation programs for blue-collar workers, the hypertension screening and referral programs, the stress management programs for managers/supervisors, and the stretching/back injury prevention programs. These programs were typically offered in response to a felt need expressed by management or workers and were not usually supported by epidemiologic or needs assessment data. The most common program was not theory driven, but was developed based on the experiences of the practitioner and of their colleagues at other worksites.

In addition, different locations within the same organization would develop and implement their own programs. Although this approach had the advantage of being responsive to the needs of the workers at that particular location, it also created logistical problems for the practitioner and reinforced the impression that there was no central planning or long-term perspective.

At this stage, most worksite health promotion programs were not evaluated because the practitioner was busy planning the next activity and documenting the impact of the activities was not an expectation of the organization. Consequently, what was learned from each activity or program was based on the practitioner's subjective observations and was disseminated to other practitioners largely through word of mouth. Some professional organizations were sponsoring worksite-related sessions at their professional meetings, but few presentations were sharing empirical findings. As a colleague of mine once said, these were "this is what we did, we liked it, you will like it too" presentations. While these presentations provided valuable information for the practitioner to help generate new strategies or activities, they did little to advance the profession.

Also during this stage, there seemed to be a growing interest in worksites among the academic community. This could probably be attributed to a number of factors, the most important of which was the increased interest on the part of students wanting to enter a growing job market. As a result, academic departments started to expand their programs to include worksite settings in their classes, practicums, and internships. The end result was an increase in health promotion and health education trained practitioners entering the worksite health promotion profession, which had a significant impact on the evolution of worksite health promotion and opened the door to the growth stage of worksite programs.

Growth of Worksite Health Promotion

I'm not sure what I'll die of, but hope it's not something I could have prevented.

Ashleigh Brilliant

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The growth stage of worksite health promotion is distinguished by two types of programs: 1) those that offer a menu of interventions targeted toward a variety of risk factors and 2) those that incorporate a comprehensive, integrated approach to worker health (O'Donnell and Ainsworth, 1984). The majority of worksite programs today are of the menu type. Also called "cafeteria programs" these programs offer the worker a variety of interventions from which they can pick and choose, like ordering from a menu. Some of the activities are designed to impact the risk of disease while others are developed to increase awareness or morale. Many programs target those diseases or health problems with multiple risk factors such as cardiovascular disease (Erfurt, Foote, and Heirich, 1991; Glasgow, Terborg, Hollis, Severson, and Boles, 1995) or cancer (Abrams,et al., 1994; Tilley, et al., 1997) while others are available throughout the year, such as smoking cessation or fitness programs. The strongest evidence we have supporting the effectiveness of worksite health promotion programs is based on evaluations of these types of programs (Wilson, et al., 1996; Wilson, 1996).

The second type of worksite health promotion program is offered by only a minority of worksites and is really the gold standard. It is designed to provide a comprehensive, integrated approach to worker health (DeJoy and Southern, 1993; O'Donnell and Ainsworth, 1984) , transcending the individual or group behavior change approach to include environmental, organizational, and community-wide supports conducive to health. Providing environmental supports for positive health behaviors has long been recognized as an important component of health promotion programs (Green and Kreuter, 1991). At the worksite this could include redesigning the work space, providing appropriate protective equipment, modifying company cafeteria menus to be more nutritionally sound, and removing cigarette vending machines from the worksite.

Organizational support for worker health is an idea that has blossomed in the last decade. The early organizational interventions included policies against drug use at the worksite or working under the influence of drugs (Roman and Blum, 1996). These actions opened to door to drug screening of new applicants and current employees suspected of being under the influence. Recent policies include the adoption of no smoking policies at the worksite and policies against hiring smokers, both of which have been upheld in the courts, and mandatory use of seatbelts while operating company vehicles.

Community support recognizes that the employee's family, and the communities in which they reside, have a tremendous influence over his/her health. Organizations that integrate community support into their health promotion interventions greatly increase the likelihood of maximizing worker health (Wilson, et al., 1996; DeJoy and Southern, 1993). Community support could include sponsoring walk/runs, opening child care facilities, donating products to community-based organizations, and financially sponsoring community events.

A comprehensive, integrated program requires considerable commitment on the part of the organization. It requires

a willingness on the part of the organization to view each worker as a complete person who is a key to the organization's success. With this philosophy, the long-term viability of the organization depends considerably on the health and well-being of its employees.

During the growth stage we have witnessed an exponential growth in the sophistication of worksite health promotion programs. A considerable number of programs being developed and conducted are theory-driven and use sound evaluation principles to determine impact. Research in worksites is continuing to grow with more and more studies documenting the financial and health-related impact of worksite programs (Aldana, In press; O'Donnell, In press). Organizations are taking a long-term perspective in the planning and coordinating of programs and most programs are being offered to all employees irrespective of position or location.

Today, the vast majority of worksite practitioners have some health-related training with most coming from health promotion, health education, exercise/fitness, and nutrition disciplines. Worksites have recognized the importance of professional certification as a means of quality control and advancing the conduct of worksite health. Many worksite practitioners are Certified Health Education Specialists. One professional organization has opened discussion on a separate certification specifically for worksite health promotion practitioners. The Association for Worksite Health Promotion has also developed a certification for managers of worksite health promotion programs. The Certified Worksite Health Promotion Director requires an individual to be competent in business management and human resource management in addition to program management (Golaszewski, Couzelis, Corry, Baun, and Eickhoff-Shemek, 1994).

Amazingly, these advances have occurred in an environment that has not always been hospitable to worker health or organizational stability. Terms such as down-sizing, outsourcing, moving operations abroad, re-engineering, disease management, risk-rating, and capitated plans have become standard in the business language. These issues have created considerable turmoil for organizations, the complete impact of which is unknown. Considering all of the changes that have occurred in work organizations, worksite health promotion has fared considerably well as evidenced by the breadth and depth of programs offered. The key questions we face right now are what lies ahead of us and how will we adapt to future organizational and professional changes?

Maturation of Worksite Health Promotion

Everything that can be invented has been invented
Charles H. Duell, Commissioner, U.S. Office of Patents, 1899

The future of worksite health promotion relies on the maturation of the profession. In this maturation stage, practitioners and programs will depend on their ability to adapt to constantly changing business and health care environments. This adaptation will move the practitioner away from traditional health promotion strategies and activities designed to impact individual risk factors to approaches that are integrated with the health care and public health communities and designed to create healthy organizations and healthy communities.

One strategy currently being tried in worksite settings is the use of innovative applications of new technology to provide cost-effective health promotion interventions. Some companies are testing the implementation of behavioral interventions through interactive web pages. Employees dial into these pages using their work or home computers and explore the behavior change program, a concept similar to the old self-help brochure but intricately more sophisticated and tailored to the individual. This is a significant departure from the traditional "one size fits all" health education program. For example, live action video can be interwoven into the software program to provide information or emphasize strategies, self-assessments can be calculated within seconds with the results being fed back immediately to the individual in the form of another strategy or activity, data can be continuously collected about the status of the individual and where he/she falls in the change process, and reinforcements can be tailored specifically to the individual and forwarded at periodic times to help maintain the behavior. Although this will not be effective for all individuals wishing to modify their health, this approach could be a tremendous help to the worksite practitioner who is frequently attempting to serve a large population, many of which are scattered around at multiple locations.

Another trend is the integration of worksite health promotion programs with the public health and health care communities (Stokols, Pelletier, and Fielding, 1995). Companies that offer screenings and health risk assessments are already routinely referring high risk employees to their physician. However, this new level of integration will allow physicians to monitor the patient's recovery after they return to work and enable the physician to work with the worksite practitioner to plan and implement a coordinated rehabilitation program. Also in the future, worksites will develop coalitions with community-based health organizations to provide services to their employees, particularly those traditionally more difficult to serve such as mobile workers, retirees, uninsured employees, and those working in rural harder-to-reach locations. Many times, these employees only link to health services is through the community-based organizations and clinics located in the communities in which they work. Careful coordination between the worksite practitioner and these organizations can fill the gaps in worksite-provided services and support the community-based organization at the same time.

This coordinated effort among worksite practitioners, public health organizations, and medical care providers will be integrated with organizational strategies for the purpose of creating a healthy organization. Needless to say, organizations have been keenly interested in worker productivity and its effect on the organization's bottom-line. Considerable research has examined the link between productivity and or

ganizational, environmental, and individual factors (Cook and Wall, 1980; Karasek, Baker, Marxer, Ahlbom, Theorell, 1981; DeJoy, Gershon, Murphy, and Wilson, 1996). Recently, organizations have been developing activities designed to improve worker health in an attempt to enhance productivity and impact the corporate profitability through reduced health care costs (Golaszewski, Snow, Lynch, Yen, and Solomita, 1992; Edington, Yen, and Witting, 1997).

The healthy organization concept centers on the premise that organizations that foster employee health and well-being are also profitable and competitive in the marketplace. The concept recognizes that work can have a positive impact on employee self-esteem, satisfaction, and health which, in turn, are integral to the effectiveness of the organization. In the future, organizations will adopt a proactive approach to positively increase worker health, satisfaction, and productivity with the understanding that it will impact their bottom line (DeJoy, Wilson, Griffin, and Peer, 1997). Worksite health promotion practitioners will play a key role in this approach because it will require assessment, coalition building, intervention development, implementation, communication, and evaluation skills which they have been trained to employ. Furthermore, a healthy organization cannot become a reality without the support of the community in which it resides. This support may be demonstrated in a variety of ways, but it must be continuous and integrated throughout healthy organization strategies and activities.

In addition to disciplinary competencies in the health and behavioral sciences, the maturation of worksite health promotion will require the worksite practitioner to be technologically savvy, able to access a variety of software, download information and graphics, and update web pages with ease. They will need to be an accomplished networker and coalition builder, establishing alliances and directing partnerships within the organization and in the community. They will need to be financially astute, understanding organizational finances as well as the cost-effectiveness and cost-benefits of their programs. In the future, the worksite health promotion practitioner must have strong evaluation skills and be able and willing to document the impact of their activities. Finally, future practitioners must be able to work in a multicultural environment and be able to support employees at home and around the world. In our global marketplace, practitioners will be asked to play a larger role in providing health-related services for all employees, regardless of the part of the world in which they work.

Summary and Conclusions

There are three kinds of people. Those who make things happen, those who watch things happen, and those who wonder what happened.

Woody Allen

Health promotion programs in worksites have a relatively brief history compared to other settings. Worksite activities designed to impact health did not become prevalent until the late 1970's. Before that, activities were offered largely for morale or recruitment purposes or were reactive, unsystematic activities. Today, worksite programs are reflective of the advances made in the health promotion profession, in general. Many programs are grounded in a conceptual or theoretical framework and implemented using sound, proven behavior change strategies. Practitioners are beginning to realize the impact the organization and environment has on worker health and are incorporating organizational and environmental activities into their programs.

The challenge for the next decade will be to move worksite health beyond the narrow confines of individual behavior change or reducing health insurance costs to embrace quality of work issues and assume a leadership role in impacting the quality of life for the entire community. Health promotion programs have historically played a minor role as a "add on" or "benefit" within work organizations. Taking a leadership role in maximizing the human capital of an organization will assure worksite health promotion practitioners of a enduring effect on the organization and, consequently, a permanent place as a core function of the organization. The business and health care environments are changing so rapidly that, if we don't play an active role in making things happen, we will soon be wondering what happened.

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