

CHAPTER 1

Evolution of Health Education, Health Promotion, and Wellness Programs

EARLY ORIGINS

A search for the origins of health promotion leads to the earliest civilizations. Certainly the fundamental needs of shelter, food, water, and safety are health related, and the writings of the Babylonians, Egyptians, and Old Testament Israelites indicate that various health promotion techniques were utilized.

For example, there were community systems to collect rain water or otherwise provide safe drinking water. There were various sewage disposal methods, including the use of earth closets. Personal cleanliness was advocated. Intoxication was recognized as troublesome. Disease, though not understood, was known to be contagious and various forms of quarantine were used, as were herbal medicines. Days of rest were prescribed and sexual conduct was regulated. Dietary restrictions were numerous, and various sanitary restrictions governed the supply and preparation of food. Regulations regarding menstruation, pregnancy, and child-birth evolved. Exercise was advocated. In some places building regulations were set, and street cleaning and garbage removal began to occur regularly. Mental health and spiritual health (e.g., a sense of harmony) were advocated.

As more was learned about disease transmission, more methods to help control and prevent disease were instituted, such as immunization. Various health care facilities and public health systems were developed to provide better treatment and prevention services. In most early civilizations, health and religion overlapped. Organized religion sponsored many of the earliest health care facilities and practitioners of the healing arts. At various times peoples have portrayed God as visiting disease and destruction on sinful people, as well as being the source of healing for righteous people. In some civilizations, the first temples were also the first hospitals. Medical missionaries have been common to many religions and societies. Regardless of the motivation, religious practitioners' desire to improve

the health and well-being of others has been a powerful force in the history of medicine, health education, and health promotion.

Among the positive contributions of religion has been its influence on government institutions and on those who govern. The impact of religion and government on health promotion and wellness programs cannot be fully separated, because many people tend to express their religious commitment through government involvement. Further, the tremendous impact of religion and government on these programs is matched only by the impact of science and technology.

The roots of today's health promotion and wellness programs lie in the Industrial Revolution. The creation of large factories meant that thousands of people were brought together in congested, unsafe worksites located in congested, unsafe cities. The inhumane conditions gave rise to numerous labor laws and worksite programs, not to mention labor unions demanding that the perspective of workers be considered.

Labor union negotiations resulted in various insurance programs that changed medical facility and service utilization patterns. Insurance programs became more accepted by society and more pervasive, and they eventually evolved into nationalized systems that encompassed prevention as well. Economics have always been at the center of such negotiations, and cost reduction or cost shifting was frequently among the most important issues that arose.

Science and technology have had a significant impact on prevention by providing an understanding of the causative roles of pathogens and how to immunize people. Similarly, discovery of the effects of diet, exercise, and substance abuse on chronic disease led to the evolution and elevation of prevention programs. However, science and technology have contributed more to the curative side of disease and disorder through the assortment of disease-specific miracle drugs, therapies, and surgeries they have made available. Of course, the ascendance of technology in health care caused costs to escalate rapidly and making health care accessible and affordable to all became an important goal of providers and third-party payers.

CONTEMPORARY MILESTONES

There are numerous possible starting points from which to choose when discussing the contemporary focus on health promotion and wellness. According to a widely quoted definition, health promotion is "the combination of educational and environmental supports for actions and conditions of living conducive to health."¹ This definition provides a useful framework for describing the contemporary situation.

Health education has traditionally been used to refer to educational interventions. Over time this term has become more inclusive (and coincidentally such

interventions have become more effective). The basic approach evolved from the moralistic (“Don’t do it because God or the church doesn’t want you to.”) to the legalistic (“Don’t do it because it’s against the law.”). With this shift, educational programs began to focus on possible harmful effects of certain substances or behaviors and why they were illegal. Of course, one objective was to explain what would happen to lawbreakers if caught. Another was to urge legislators and others to engage in social engineering, such as passing laws mandating safety-related provisions, such as the use of air bags.

The educational process has changed as well. The original models were cognitive (presenting the facts), but they were replaced by affective models (changing attitudes), peer-counseling and peer support models, decision-making models, alternative models, and, most recently, behavioral models. For a discussion of these models and how health education and health promotion have evolved, see *Community Health Education: Setting Roles and Skills for the Twenty-First Century*.²

This paradigm shift in the profession did not just happen. It was made to happen by practicing professionals and college professors whose research and writing focused on finding ways to increase the effectiveness of the programs they advocated.

As data accumulated and the profession matured, more leadership efforts were devoted to institutionalizing health education, health promotion, and wellness programming, primarily through government mandates and through focusing on economic issues in business and industry. The creation of the President’s Committee on Health Education in 1973 was an important early event. This committee, among other things, legitimized a nationwide emphasis on health education and an expanded role for government in developing model programs and providing seed money for their implementation. It recommended, for example, creation of a National Center for Health Education, which occurred in 1975. The Center successfully pushed for expanded worksite programming as well as nationwide programming, professional credentialing, and comprehensive school health education programs.

Two seminal works that influenced the profession were the 1979 Surgeon General’s report on health promotion entitled *Healthy People*, and the 1980 report entitled *Promoting Health, Preventing Disease: Objectives for the Nation*. In 1980, the U.S. Government also created a separate Department of Education in the Department of Health and Human Services and gave it responsibility for supporting health education, health promotion, and wellness programming. In 1981, *Objectives for the Nation in Disease Prevention and Health Promotion* was adopted as policy in the United States and again in 2001 with new goals established.

As the profession gained in national prominence, certifying health education and health promotion specialists and upgrading and standardizing college prepa-

ration programs at both the undergraduate and graduate levels became important goals. Certification standards and procedures were finalized in 1988 and national credentialing began in 1990. Finally, the following year, 1991, saw the publication of *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* and *Healthy Communities 2000: Model Standards*. Subsequently *Healthy People 2010* was published and is helping to shift public policy toward prevention through health education and health promotion programming in communities.

The documents, consultation, and seed money pegged to these initiatives were intended to facilitate the meeting of the *Healthy People* and *Healthy Communities* standards by the year 2000 and the newer goals by 2010. Local units of government were charged with taking the lead in this effort:

Government is “residual guarantor” of health services, whether they are provided directly or through community agencies. Every locale and population should be served by a unit of government that takes a leadership role in assuring the public’s health. This concept has become known as “a governmental presence at the local level.”³

Each local unit of government was given the responsibility of coordinating planning and ensuring that local standards would be established and programming devised to ensure they are met:

The government at the local level has the responsibility for ensuring that a health problem is monitored and that services to correct that problem are available. The state government must monitor the effectiveness of local efforts to control health problems and act as a residual guarantor of services when community resources are inadequate, recognizing of course that state resources are also limited.⁴

As the *Healthy Communities 2000* and *Healthy Communities 2010* documents noted, communities will always need multiple interventions and overlapping programs. The problems and opportunities are too great to be left to government alone:

Many of the activities . . . go beyond the activities customarily carried out by state and local governmental agencies. Even in those areas where health agencies are extensively involved, prevention is a shared responsibility of the public and private sector.⁵

In *Healthy People 2010* there are two overarching goals:

1. Increase quality and years of healthy life.
2. Eliminate health disparities.⁶

As we move further into the twenty-first century, the United States is placing a greater emphasis on health, health education, health promotion, and wellness

programming than ever before in its history, and several other nations are undergoing the same shift in priorities. The World Health Organization has become much more active in disease management, mitigation, and now, prevention. Goals are being set, public and private sector efforts are being coordinated, seed money is being provided, and results are being monitored. Some of the results here in the United States—increased highway safety and reductions in alcohol misuse and tobacco use—are heartening. The results, of course, are mixed, and motivations vary over time. Hospitals have done much more prevention programming in spite of budget restrictions. Health care reorganization and managed care have been redefining the roles of hospitals. Some states have initiated comprehensive school-based health education programs. Many corporations have provided employee wellness programs, desiring to increase production and employee longevity and reduce absenteeism and employee turnover.

Government regulations and worksite policies are forcing people to engage in healthier behavior. Yet as longevity increases, more disease among the elderly occurs and more dollars are spent caring for this growing segment of society. One thing is certain: there are more opportunities for health education, health promotion, and wellness specialists than ever before, as well as more agencies providing related services. It follows that more and better skilled managers, administrators, and leaders are needed in such agencies.

ACTION-BASED CONCEPT

Managers should read about and be able to discuss historical milestones relevant to their profession and their agency. An understanding of history is always important, because it is the only means of fully understanding the present and anticipating the future.

TRENDS

A review of the history of health promotion programming reveals its roots in the earlier civilizations. After all, health is integrally related to length and quality of life. Religion has also consistently played a role in health promotion. Most religions have advocated maintaining personal health and accepting responsibility for improving the health of others. Likewise, governments typically have acted to improve the collective health of the people being governed. Over the centuries, they have regulated activities that negatively impact health. Their focus

has been on promoting the quality of life more than the length of life, although the two cannot be fully separated.

Business and industry have also been major players in health education and health promotion programming since the Industrial Revolution, admittedly prodded into action by labor unions. Early efforts to improve safety and eliminate inhumane working conditions have evolved into comprehensive employee wellness programs.

Science and technology are implicated in the spread of certain health problems as well as in the improvement of health. Discovery of the etiology and epidemiology of various diseases and disorders has made numerous prevention and early intervention actions possible, some of which government has mandated (e.g., the addition of iodine to salt and of fluoride to drinking water). In the last few decades, the science of health education and health promotion has matured and has demonstrated the ability to produce significant results. Major gains have been made in extending the length of life and improving the quality of life, and the practitioners have become recognized as constituting a profession. The improved effectiveness of programs and the recognition of the profession have jointly led to institutionalization.

Philosophically, one can always ask how much programming is enough and, similarly, how much government is too much. All people will ultimately die, and the prevention of health problems, by extending life, gives rise to other problems associated with old age. Health professionals must continue to focus on the quality of life and the prevention of premature death and must accept that death and its antecedent diseases and disorders cannot be postponed forever. Increasingly, it is being recognized that death with dignity is desirable.

Nonetheless, health education and promotion specialists must always remember that they deal with matters of life and death and with quality of life issues. They are often in a position to prevent disease and premature death and concurrently improve the quality of life. Such responsibility is sobering—even awesome—and requires a commitment to act in accordance with the standards of their profession. This can include providing the best possible leadership for a health education, health promotion, or wellness program.

ACTION-BASED CONCEPT

Managers must generally take quality improvement into account. Quality improvement should be an important element of virtually every decision made, whether it be improvement of the quality of life of clients, the quality of services or programs provided, the quality of staff, or the quality of decision-making processes.

The purpose of this textbook is to provide an introduction to the fundamental concepts of management, administration, and leadership and to demonstrate their application in a variety of health education, health promotion, and wellness programs. It is the authors' sincere desire that this book stimulates interest in the management and administration of such programs and improves the practice of those who have migrated from education to management and administration. The profession must have competent leaders, administrators, and managers if it is to warrant the trust placed in it and justify the dollars spent on health promotion. Can the profession do less than adequately prepare leaders, administrators, and managers for the programs they have helped to create?

CONCLUSION

Improving the health of individuals and communities was a concern of the earliest civilizations and it remains a concern today. Indeed, health education and promotion has evolved into a profession, and certification indicating adequacy of training and competence is now available.

Health promotion programming is pervasive in the private and public sectors of most industrialized societies, and it has even been suggested that we are in a "golden age" of health education and promotion. Yet the question remains whether the profession will continue to flourish (because its practice has improved) or whether it will begin to decline (because it has not lived up to its potential). The answer to this question is largely in the hands of today's practitioners.

IN-BASKET ASSIGNMENTS

TO: Health Education and Health Promotion Specialists
FROM: The Director
RE: Terminology and Titles

I don't really understand the difference between health education and health promotion. Please provide me with a written summary, including definitions, examples, and areas of overlap. Should we be using one term or the other, or both?

I would like this information by the first of the month for a discussion at our staff meeting. A page or two will probably be sufficient.

Thanks!

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TO: Health Education and Health Promotion Specialists
FROM: The Director
RE: Grant Application

We are working on a grant application, and I need two or three paragraphs that describe the Healthy People 2000 and the Healthy Communities 2000 projects so that I can tie our health promotion proposal to them.

I need the paragraphs by Monday. Please expedite!

MANAGEMENT CASE STUDY

Setting

A state health department was preparing to hire a health promotion specialist to stimulate and coordinate activities throughout the state. The position was approved and budgeted.

Problem

The individuals who needed to approve the job description objected to the requirement that applicants be graduates of a Society of Public Health Education/American Alliance of Health Education (SoPHE/AAHE)—approved program or be a certified health education specialist. It was argued that this would unnecessarily restrict the applicant pool.

Alternatives Considered

One alternative considered was to include the phrase “or equivalent work experience” so as not to close the door on nurses and other health care providers who might apply.

Another was to state “CHES preferred or completion of CHES certification within the first year of employment.” Yet a third alternative was not to have a certification requirement at all.

Action Taken

The job description was approved so as to include “CHES certification preferred or to be obtained within the first year of employment.” The rationale given

was that CHES certification would ensure that the leader of this state initiative would have appropriate breadth and depth of understanding of professional issues. However, it was accepted that work study and self study were alternative ways to get to the desired point and should not be prohibited.

OUTCOME

A certified health education specialist was among the applicants. She was hired, and the state health department has made good progress toward meeting its goals.

DISCUSSION QUESTIONS

1. How important is the CHES certification? What are the certification criteria? How does one become certified?
2. After reviewing the criteria, explain why CHES certification should or should not be included in a job description. Is there a clear-cut decision that is always right?
3. How might one respond to the claim that requiring CHES certification unnecessarily limits the applicant pool?
4. Should graduating from a Society of Public Health Education- or American Alliance of Health Education-approved baccalaureate program or obtaining a CEPH-approved graduate degree give a candidate an advantage over someone who has migrated to the profession from a related health care field?
5. Are there other strategies that could have been used to ensure an experienced and competent individual was hired for the position?

NOTES

1. L. Green and M. Kreuter, *Health Promotion Planning: An Educational and Environmental Approach* (Mountain View, CA: Mayfield Publishing, 1993): 17.
2. D.J. Breckon, J.R. Harvey, and B. Lancaster, *Community Health Education: Setting Roles and Skills for the Twenty-First Century*, 3rd ed. (Gaithersburg, MD: Aspen Publishers, 1994).
3. *Healthy Communities 2000: Model Standards* (Washington, DC: American Public Health Association, 1991): xvii.
4. *Healthy Communities 2000*: 443.
5. *Healthy Communities 2000*: 443.
6. *Healthy People 2010* (Washington, DC: U.S. Department of Health and Human Services, 2001).

