CHAPTER 1

WHAT ARE HEALTH PROMOTION PROGRAMS?

Carl I. Fertman, Diane D. Allensworth, and M. Elaine Auld

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Health, Health Promotion, and Health Promotion Programs

The World Health Organization (WHO, 1947) defined *health* as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity." While most of us can identify when we are sick or have some infirmity, identifying the characteristics of complete physical, mental, and social well-being is often a bit more difficult. What does complete physical, mental, and social well-being look like? How will we know when or if we arrive at that state? If it is achieved, does it mean that we will not succumb to any disease, from the common cold to cancer?

In 1986, the first International Conference of Health Promotion, held in Ottawa, Canada, issued the *Ottawa Charter for Health Promotion*, which defined health in a broader perspective: "health has been considered less as an abstract state and more as a means to an end which is expressed in functional terms as a resource which permits people to lead an individually, socially, and economically productive life" (WHO, 1986). Accordingly, health in this view is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities.

Arnold and Breen (2006) identified the characteristics of health not only as well-being but also as a balanced state, growth, functionality, wholeness, transcendence, and empowerment, and as a resource. Perhaps the view of

LEARNING OBJECTIVES

- Define *health* and *health promotion*, and describe the role of health promotion in fostering good health and quality of life.
- Summarize the key historical developments in health promotion over the past century.
- Describe the impact of Healthy People 2020 and the Patient Protection and Affordable Care Act of 2010 on health promotion.
- Compare and contrast health education and health promotion.
- Describe the nature and advantages of each health promotion program setting and identify health promotion program stakeholders.
- Explain how the evolving U.S. health care system and health technology create opportunities and challenges for health promotion programs.

health as a balanced state between the individual (host), agents (such as bacteria, viruses, and toxins), and the environment is one of the most familiar. Most individuals can readily understand that occasionally the host-agent interaction becomes unbalanced and the host (the individual) no longer is able to ward off the agent (for example, when bacteria overcome a person's natural defenses, making the individual sick).

Clearly, good health doesn't just happen; it's more than just luck. Although being born with good genes and having access to health care are important, they do not provide a guaranteed ticket to wellness. The food we eat, levels of physical activity, exposure to tobacco smoke, social interactions, the environment in which we live, and many other factors ultimately influence our health or lack thereof. The health of individuals and the health of our communities reflect the unique combination of biological, psychological, social, intellectual, and spiritual components as well as the cultural, economic, and political environments in which we live. Exploration of the interaction between individuals and their environment in regard to health has been a hallmark in the progress of nations in promoting and improving the health of individuals and the community at large. This ecological perspective on health emphasizes the interaction between and interdependence of factors within and across levels of a health problem. The *ecological perspective* highlights people's interaction with their physical and sociocultural environments. McLeroy, Bibeau, Steckler, and Glanz (1988) identified three levels of influence for health-related behaviors and conditions: (1) the *intrapersonal or individual level*, (2) the *interpersonal level*, and (3) the *population level*. The population level encompasses three types of factors: institutional or organizational factors, social capital factors, and public policy factors (Table 1.1).

Table 1.1 Ecological Health Perspective: Levels of Influence

Concept	Definition
Intrapersonal level	Individual characteristics that influence behavior, such as knowledge, attitudes, beliefs, and personality traits
Interpersonal level	Interpersonal processes and primary groups, including family, friends, and peers, that provide social identity, support, and role definition
Population level	
Institutional factors	Rules, regulations, policies, and informal structures that may constrain or promote recommended behaviors
Social capital factors	Social networks and norms or standards that is formal or informal among individuals, groups, or organizations
Public policy factors	Local, state, and federal policies and laws that regulate or support healthy actions and practices for prevention, early detection, control, and management of disease

Source: Adapted from McLeroy, Bibeau, Steckler, and Glanz, 1988.

The ecological health perspective helps to elucidate multiple levels of influence on individuals' behavior and recognizes that individual behavior both shapes and is shaped by the environment. Using the ecological perspective as a point of reference, health promotion is viewed as planned change of health-related lifestyles and life conditions through a variety of individual, interpersonal, and population-level changes.

Health promotion programs provide planned, organized, and structured activities and events over time that focus on helping individuals make informed decisions about their health. In addition, health promotion programs promote policy, environmental, regulatory, organizational, and legislative changes at various levels of government and organizations. These two complementary types of interventions are designed to achieve specific objectives that will improve the health of individuals as well as, potentially, all individuals at a site. Health promotion programs are now designed to take advantage of the pivotal position of their setting within schools, workplaces, *health care organizations*, or communities to reach children, adults, and families by combining interventions in an integrated, systemic manner.

This focus on planned change in health promotion is applied among individuals in varied settings and at any stage in the natural history of an illness or health problem. Using a framework proposed by Leavell and Clark (1965), health promotion programs can help prevent new cases or incidents of a health problem (for example, preventing falls among the elderly, smoking and drug abuse among middle school and high school students, or risky drinking among college students). These are programs that take action prior to the onset of a health problem to intercept its causation or to modify its course before people are involved. This level of health promotion is called *primary prevention*. Health promotion programs can interrupt problematic behaviors among those who are engaged in unhealthy decision making and perhaps showing early signs of disease or disability. This type of health promotion is called *secondary prevention*. Examples of this type of health promotion program include smoking cessation programs for tobacco users and physical activity and nutrition programs for overweight and sedentary individuals. Health promotion programs can improve the life of individuals with chronic illness (*tertiary prevention*). Examples are programs that work to improve the quality of life for cancer survivors or individuals with HIV/AIDS. Collectively, health promotion programs are a bridge between medicine and health and are part of an ongoing dialogue about how to improve the health and well-being of individuals across settings. Following are some examples of strategies for primary, secondary, and tertiary prevention applied in health promotion and disease prevention.

Primary health promotion and disease prevention strategies include

- Identifying and strengthening protective ecological conditions that are conducive to health
- Identifying and reducing various health risks

Secondary health promotion and disease prevention strategies address low-risk factors and high protective factors through

- Identifying, adopting, and reinforcing specific protective behaviors
- Early detection and reduction of existing health problems

Tertiary health promotion and disease prevention strategies include

- Improving the quality of life of individuals affected by health problems
- Avoiding deterioration, reducing complications from specific disorders, and preventing relapse into risky behaviors

Health promotion programs are designed to work with a priority population (in the past called a target population)—a defined group of individuals who share some common characteristics related to the health concern being addressed. Programs are planned, implemented, and evaluated to influence the health of a priority population. The foundation of any successful program lies in gathering information about a priority population's health concerns, needs, knowledge, attitudes, skills, and desires related to the disease focus. At the planning stage, it is also important to engage schools, workplaces, health care organizations, and communities where the priority population lives and interacts to seek their cooperation and collaboration.

Finally, health promotion programs are concerned with prevention of the root causes of poor health and lack of well-being resulting from discrimination, racism, or environmental assaults—in other words, the social determinants of health. Addressing root causes of health problems is often linked to the concept of social justice. Social justice is the belief that every individual and group is entitled to fair and equal rights and equal participation in social, educational, and economic opportunities. Health promotion programs have a role in increasing understanding of oppression and inequality and taking action to improve the quality of life for everyone.

Historical Context for Health Promotion

Kickbush and Payne (2003) identified three major revolutionary steps in the quest to promote healthy individuals and healthy communities. The first step, which focused on addressing sanitary conditions and infectious

diseases, occurred in the mid-19th century. The second step was a shift in community health practices that occurred in 1974 with the release of the *Lalonde report*, which identified evidence that an unhealthy lifestyle contributed more to premature illness and death than lack of health care access (Lalonde, 1974). This report set the stage for health promotion efforts. The third and current revolutionary step in promoting health for everyone challenges us to identify the various combinations of forces that influence the health of a population—the social determinants to health.

In the mid-19th century, John Snow, a physician in London, traced the source of cholera in a community to the source of water for that community. By removing the pump handle on the community's water supply, he prevented the agent (cholera bacteria) from invading community members (hosts). This discovery not only led to the development of the modern science of epidemiology but also helped governments recognize the need to combat infectious diseases. Initially, governmental efforts focused only on preventing the spread of infectious diseases across borders by implementing quarantine regulations (Fidler, 2003), but ultimately, additional ordinances and regulations governing sanitation and urban infrastructure were instituted at the community level. As an outgrowth of the New Deal in the United States, water and sewer systems were constructed across the nation. By the 1940s, the regulatory focus had expanded to include dairy and meat sanitation, control of venereal disease, and promotion of prenatal care and childhood vaccinations (Perdue, Gostin, & Stone, 2003).

As environmental supports for addressing infectious diseases were initiated (for example, potable water and vaccinations), deaths from infectious diseases were reduced. Compared with people who lived a century ago, most people in our nation and other developed nations are living longer and have a better quality of life—and better health. While new infectious diseases (e.g., HIV/AIDS, bird flu, MRSA, Ebola, Zika virus) have emerged since the end of the 20th century and continue to demand the attention of health workers, the emphasis of health promotion shifted in the last quarter of the 20th century to focus on the prevention and treatment of chronic diseases and injury, which are the leading causes of illness and death. This change was stimulated, in part, by the Lalonde report, which observed in 1974 that health was determined more by lifestyle than by human biology or genetics, environmental toxins, or access to appropriate health care. It was estimated that one's lifestyle—specifically, those health risk behaviors practiced by individuals—could account for up to 50% of premature illness and death. Substituting healthy behaviors, such as avoiding tobacco use, choosing a diet that was not high in sugar or calories, and engaging in regular physical activity, for high-risk behaviors (tobacco

use, poor diet, and a sedentary lifestyle) could prevent the development of most chronic diseases, including heart disease, diabetes, and cancer (Breslow, 1999). With recognition of the importance of one's lifestyle in the ultimate manifestations of disease, a shift in the understanding of disease causation occurred, making *health status* the responsibility not only of the physician, who ensures health with curative treatments, but also of the individual, whose choice of lifestyle plays an important role in preventing disease.

The Lalonde report set the stage for the WHO meeting in which the *Ottawa Charter for Health Promotion* (WHO, 1986) was developed. This pivotal report was a milestone in international recognition of the value of health promotion. The report outlined five specific strategies (actions) for health promotion:

1. Develop healthy public policy.
2. Develop personal skills.
3. Strengthen community action.
4. Create supportive environments.
5. Reorient health services.

In the United States, the Lalonde report formed the foundation for *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* (U.S. Department of Health and Human Services, 1979), which sets national goals for reducing premature deaths. *Healthy People* is a public-private initiative, which has been updated every 10 years since its first release in 1980. (*Healthy People* is discussed in the next chapter section). In the subsequent 40 years since the first *Healthy People* report, the focus on the root causes of premature illness and death now include an understanding of the social determinants of health. Choices individuals make about individual health behaviors are determined not only by personal choice but also by opportunities or lack thereof in the places that they live, work, and play. This was also documented by the HHS Secretary's Task Force Report on Black and Minority Health (Heckler Report) in 1985, which revealed the existence of health disparities among racial and ethnic minorities in the United States.

In 1997, the *Jakarta Declaration on Leading Health Promotion into the 21st Century* (WHO, 1997) added to and refined the strategies of the *Ottawa Charter* by articulating the following priorities:

- Promote social responsibility for health.
- Increase investment for health developments in all sectors.
- Consolidate and expand partnerships for health.

- Increase community capacity and empower individuals.
- Secure an infrastructure for health promotion.

The *Jakarta Declaration* gave new prominence to the concept of the health setting as the place or social context in which people engage in daily activities in which environmental, organizational, and personal factors interact to affect health and well-being. No longer were health programs the sole province of the community or school. Various settings were to be used to promote health by reaching people who work in them, by allowing people to gain access to health services, and through the interaction of different settings. Most prominently, workplaces and health care organizations as well as schools and communities were now seen as sites for action in health promotion (WHO, 1998).

The third and current stage of health promotion started at the beginning of the 21st century with the realization that even within high-income countries there could a difference of almost 20 years in life expectancy—even in those countries that had a well-developed health care system providing care to all citizens (Kaplan, Spittel, & David, 2015). Individual decisions about health behaviors were rooted in the social environment in which people are born, live, work, and play (Marmot, 2005). The social institutions (economic systems, housing, health care system, transportation system, educational system), the surrounding environment, social relationships, and civic engagement all provide opportunities for individuals to make healthy choices—or not. One's opportunities for a healthy lifestyle are severely limited if there is no affordable low-income housing, no transportation infrastructure that allows individuals to pursue employment outside of their neighborhood, no supermarkets in the neighborhood with fresh fruits and vegetables, no safe parks in which to play or exercise, or no schools that provide a quality education in the neighborhood.

Today, health promotion is a specialized area in the health fields that involves the planned change of health-related lifestyles and life conditions through a variety of individual and environmental changes. Figure 1.1 illustrates the dynamic interaction between individual strategies and strategies for the entire population. In actuality, the distinction is somewhat artificial in that individuals constitute the population. Nonetheless, certain health promotion strategies are needed to effect changes in knowledge and skill so that population-based or environmental strategies is enacted. Although there is no question that regulatory and legislative actions generate the broadest potential behavioral changes within a population, these actions are difficult to enact and cannot be achieved without support from key stakeholders and individuals who are willing to contact their legislators to urge support for the proposed policy changes.

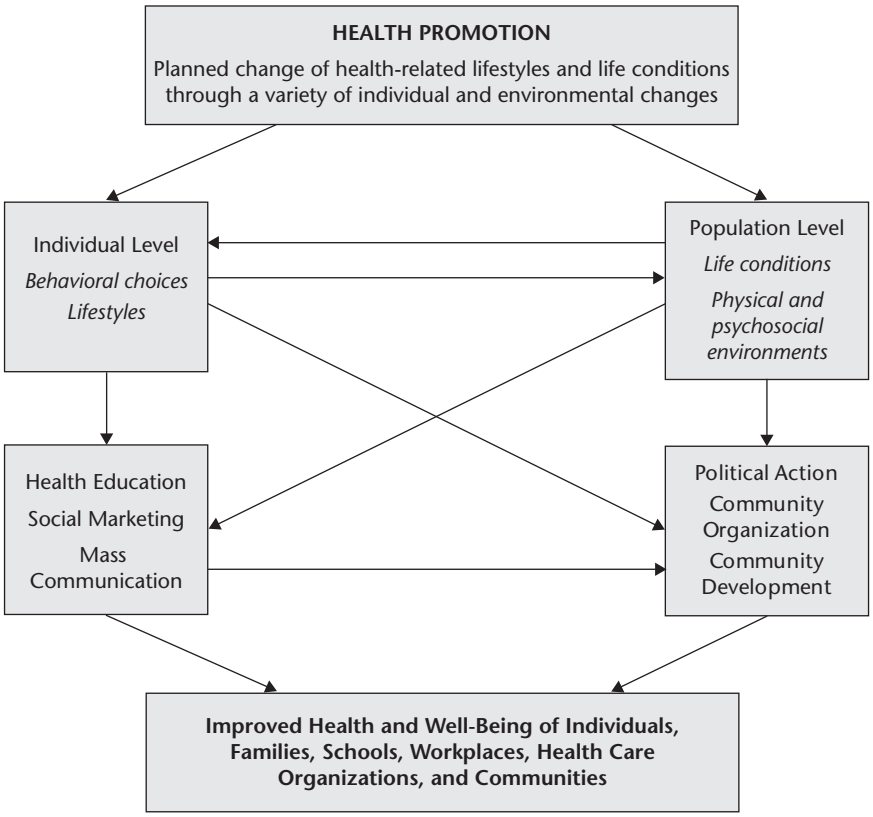

Figure 1.1 Health Promotion Interactions
Source: Adapted from Rootman and O'Neill, 2007.

Healthy People: A National Public-Private Partnership to Promote Health

Every decade since 1980, the U.S. Department of Health and Human Services has reinstituted the same public-private process and released an updated version of *Healthy People* that provides the overarching goals and objectives that will guide and direct the health promotion actions of federal agencies; local and state health departments; and practitioners, academics, and health workers at all levels of government. At the turn of the 21st century, *Healthy People* 2010 issued a comprehensive, nationwide health promotion and disease prevention agenda, which included for the first time the elimination of health disparities as a major goal.

Healthy People 2020, which was released in 2010 to be achieved by 2020, has the following goals:

- Eliminate preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote healthy development and healthy behaviors across every stage of life.

For individuals engaged in health promotion, one value of the Healthy People framework is access to national data and resources. Because the initiative addresses such a broad range of health and disease topics, health promotion program staff can usually find objectives that are similar to those they are planning to address in their locales. Using Healthy People information allows program staff to compare their local population data with national data and to use resources that have been generated nationally in order to achieve the national objectives.

Like its predecessors, *Healthy People 2020* reflects continuing efforts on the part of national and various other health promotion program sites (see Figure 1.2). It helps set programming initiatives by federal public health agencies, as well as provides a framework for state and local public health departments to address risk factors, diseases, and disorders and also the determinants of health that affect the health of individuals across health settings. Furthermore, many other national nongovernmental health and educational organizations, philanthropies, and public and private universities consult the *Healthy People 2020* objectives when setting the direction for their respective health promotion programs. This decade's initiative engages nontraditional sectors such as businesses, faith-based organizations, state and local elected officials, policy organizations, health care organizations, and all others whose actions have significant health consequences. Health promotion is not just an activity for public health workers but an endeavor that requires the collaboration of traditional and nontraditional partners, particularly because understanding of the root factors of disease has expanded to include the social determinants of health (The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020, 2008).

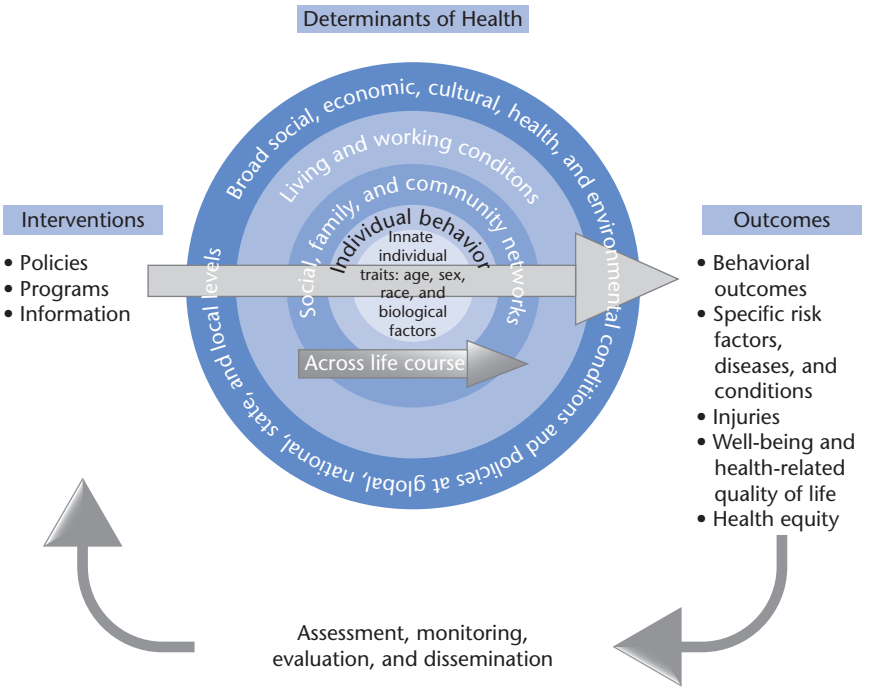

Figure 1.2 Action Model to Achieve the Overarching Goals of *Healthy People 2020*

Impact of the Patient Protection and Affordable Care Act on Health Promotion

The *Patient Protection and Affordable Care Act*, commonly known as the *Affordable Care Act* (ACA) passed in 2010, aims primarily to decrease the number of uninsured Americans (i.e., 47 million), making our country more equitable in its approach as well as reduce the overall costs of health care. The ACA provides a number of mechanisms—including mandates, subsidies, and tax credits—to employers and individuals in order to increase the coverage rate. Additional reforms are aimed at improving health care outcomes, reducing hospital readmissions, coordinating the delivery of health care, and emphasizing prevention—all to help reduce the overall cost of health care in the United States. The ACA requires insurance companies to cover all applicants and offer the same rates regardless of preexisting conditions or gender.

The ACA has a number of provisions that support a broad culture of health and health promotion across the United States. For example Section 1302 of the ACA provides for the establishment of an Employee Health Benefit (EHB) package. The law directs that the EHB be equal

in scope to the benefits covered by a typical employer plan and cover at least the following 10 general categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Furthermore individuals can no longer be denied health insurance due to a preexisting health condition. And finally children up until the age of 26 can remain on their parents' health insurance. Previously it was age 21, if they were in college.

One significant element of the ACA is the creation and participation of patient centered medical homes (PCMHs) and accountable care organizations (ACOs), which relate to how we pay for health care. An ACO and PCMH are similar in that they are health care organizations characterized by a payment and coordinated care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of individuals. A group of coordinated health care providers forms an ACO, which then provides care to a group of individuals (i.e., employees). The ACO is accountable to the individuals and the third-party payer for the quality, appropriateness, and efficiency of the health care provider (McClellan, McKethan, Lewis, Roski, & Fisher, 2010).

The significance of PCMHs and ACOs for health promotion programs is a higher degree of accountability for program quality, appropriateness, and efficiency, as well as a focus on improved program outcomes. The expectations are now for health promotion programs (as well as all health care providers and services) to use evidence-based interventions and practices; reduce variability in strategies, methods, and resources use that cannot be clinically justified; increase coordination of programs through the use of information technology and team-based initiatives, while emphasizing prevention and disease management; and give individuals (employees) a stronger voice in their own health and health care and in defining what matters (McClellan et al., 2010). The ACO's utilization of case management and care stratification lend further support to fitting and tailoring health promotion programs to different populations of individuals at varied sites (Peels et al., 2014).

The ACA provides a variety of opportunities for health education (promotion) specialists (Society for Public Health Education [SOPHE], 2013). They can apply theories and models of behavior change to improve health behaviors; assist individuals to evaluate and select a health exchange, outreach to health providers, complete the enrollment process, and navigate

the health system; and help connect patients who are being discharged from the hospital to locate community resources to help manage their condition. Health education specialists can develop health communication materials and strategies that are culturally/linguistically appropriate for populations; help develop coalitions and direct prevention grants/funding opportunities, e.g., tobacco, chronic disease, reastfeeding; and plan/conduct staff development and training, including recruitment, management, and supervision of community health workers. They can support individuals and ACO's that are required to have patient engagement and feedback (Figure 1.3). The ACA regulations require nonprofit hospitals to conduct community health needs assessments (CHNAs) every three years to maintain their nonprofit status. Health education specialists are being called up to develop and implement the CHNA surveys, as well as work with hospitals to ensure the community needs are addressed.

Health education specialists are an integral part of the health care team as their efforts help people to manage their health and prevent disease. However, since their work is not a distinct clinical service, it is not always recognized as reimbursable by third-party payers. In January 2014, the Centers for Medicaid and Medicare Services enacted a rule that allows state Medicaid programs to provide reimbursement of community

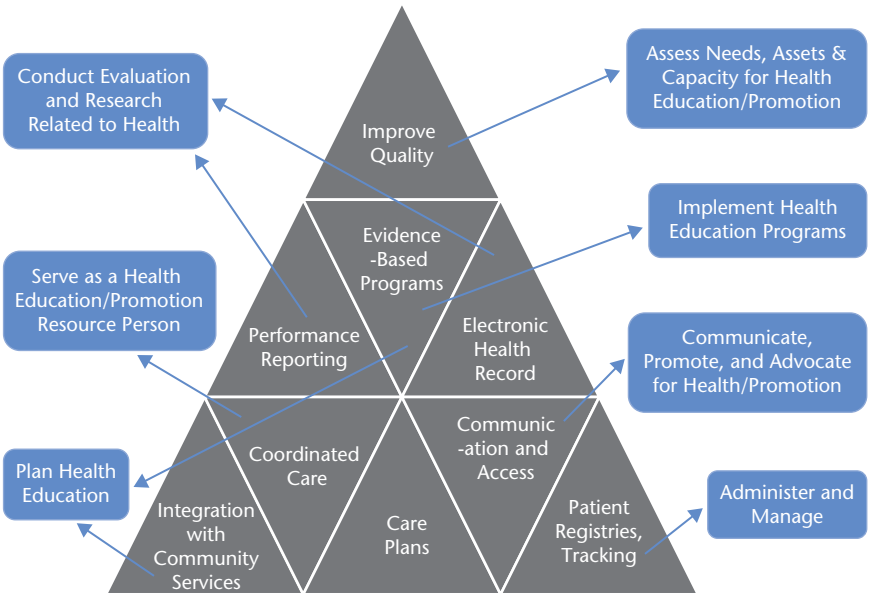

Figure 1.3 Health Educator Competencies that support ACOs

Source: SOPHE, 2013.

prevention services provided by nonlicensed practitioners (e.g., health education specialists). To be implemented, each state must amend its health plan to incorporate this rule. This represents exciting new opportunities for health education specialists in primary care, ACOs, and other settings. In summary, the ACA in its development and implementation provides a broader context and opportunities for promoting the health of individuals, families, communities, and workplaces that can help our nation achieve its health goals. Despite significant legislative and regulatory challenges that have occurred since the law was first enacted in 2010, ACA is moving forward in transforming the health care and health promotion.

Health Education and Health Promotion

Health promotion has its roots in *health education* (Chen, 2001). In the United States, health education has been in existence for more than a century. The first academic programs trained health educators to work in schools, but the role of health educators working within communities became increasingly popular in the 1940s and 1950s. Health education promotes a variety of learning experiences to facilitate voluntary action that is conducive to health (Green, Kreuter, Deeds, & Partridge, 1980). These educational experiences facilitate gaining new knowledge, adjusting attitudes, and acquiring and practicing new skills and behaviors that could change health status. The educational strategies are delivered through individual (one-to-one) or group instruction or interactive electronic media in order to promote changes in individuals, groups of individuals, or the general population. Mass communication strategies that might be used include public service announcements, webinars, social marketing techniques, and other new strategies from text messaging to blogging.

Health education as a discipline has a distinct body of knowledge, a code of ethics, a skill-based set of competencies, a rigorous system of quality assurance, and a system for credentialing health education professionals (Livingood & Auld, 2001). Approximately 250 professional preparation programs offer degrees in health education at the baccalaureate, master's, or doctoral levels. Health education was one of the first disciplines to engage in rigorous, scientific role delineation, a process that resulted in verified competencies for health education practice. The distinct occupation of health educator is recognized and tracked by the U.S. Department of Labor, which estimated that there were some 115,700 health educators in the workforce in 2014 (U.S. Department of Labor, Bureau of Labor Statistics, 2015). When health educators working in schools and businesses are added, the number is even greater. Employment of health educators is projected

Table 1.2 Components of Health Promotion Programs

Health Education to Improve	Environmental Actions to Promote
Health knowledge	• Advocacy
Health attitudes	• Environmental change
Health skills	• Legislation
Health behaviors	• Policy mandates, regulations
Health indicators	• Resource development
Health status	• Social support
	• Financial support
	• Community development
	• Organizational development

to grow 13 percent from 2014 to 2024, faster than the average for all occupations. Growth will be driven by efforts to improve health outcomes and to reduce healthcare costs by teaching people healthy habits and behaviors and explaining how to use available healthcare services. (U.S. Department of Labor, 2015).

Health promotion has been defined as the combination of two levels of action: (1) health education and (2) environmental actions to support the conditions for healthy living (Green & Kreuter, 1999). Environmental actions include strategies and interventions to promote political, economic, social, organizational, regulatory, and legislative changes that can improve the health of a population of people (Table 1.2). As noted earlier, the priorities for health promotion programs identified by WHO (1997) were promoting social responsibility for health, the empowerment of individuals, and an increase in community capacity, which requires consolidating and expanding partnerships for health within the community, securing an infrastructure for health promotion, and increasing investments for health developments in all sectors. Health promotion uses complementary strategies at both personal and population levels. In the past, *health education* was used as a term to encompass the wider range of environmental actions. These methods are now encompassed in the term *health promotion*, and a narrower definition of health education is used to emphasize the distinction.

Settings for Health Promotion Programs

Earlier in this chapter, we discussed the impact of the *Jakarta Declaration* in giving prominence to the concept of the health setting as the place or social context in which people engage in daily activities and

in which environmental, organizational, and personal factors interact to affect health and well-being. Health is promoted through interactions with people who work in various settings, through people's use of settings to gain access to health services, and through the interaction of different settings.

Schools

Schools are pivotal to the growth and development of healthy children, adolescents, and young adults. School settings include child care; preschool; kindergarten; elementary, middle, and high schools; 2-year and 4-year colleges; universities; and vocational-technical programs. Young people spend large portions of their lives in schools. Increasingly, postsecondary institutions are sites where one can find nontraditional students (for example, adults seeking a career change or retired individuals seeking enrichment). The correlation between learning and health has been documented. Graduation from high school is associated with an increase in average life span of 6 to 9 years (Wong, Shapiro, Boscardin, & Ettner, 2002). It has been noted that as a nation, we could save an annual amount of more than $17 billion in Medicaid and expenditures for health care for the uninsured if all students were to graduate (Alliance for Excellent Education, 2006).

Health Care Organizations

Health care organizations provide services and treatment to reduce the impact and burden of illness, injury, and disability and to improve the health and functioning of individuals. Health care practitioners work with individuals in community hospitals, specialty hospitals, community health centers, physician offices, clinics, rehabilitation centers, skilled nursing and long-term care facilities, and home health and other health-related entities. Traditionally, these sites are thought of as being part of the health care industry, which is one of the largest industries in the United States and provides 13.5 million jobs. The U.S. Department of Labor (2015) reports that nine of the 20 occupations projected to grow the fastest are in health care. The roughly 545,000 establishments that make up the health care industry vary greatly in size, staffing patterns, and organizational structures. About 76% of health care establishments are offices of physicians, dentists, or other health practitioners. Although hospitals constitute only 2% of all health care establishments, they employ 40% of all health care workers (Reese, 2009). While health promotion programs might seem out of place in a treatment facility, in fact, much work is done in such facilities to reduce the negative consequences associated with disease.

Communities

Communities are usually defined as places where people live—for example, neighborhoods, towns, villages, cities, and suburbs. However, communities are more than physical settings. They are also groups of people who come together for a common purpose. The people do not need to live near each other. People are members of many different communities at the same time (families, cultural and racial groups, faith organizations, sports team fans, hobby enthusiasts, motorcycle riders, hunger awareness groups, environmental organizations, animal rights groups, and so on). These community groups often have their own physical locations (for example, community recreation centers, golf, swimming, and tennis clubs; temples, churches, and mosques; or parks). These affinity groups all exist within communities, as part of communities, and at the same time, they are their own community. Health promotion programs frequently seek out people both in the physical environment of the neighborhood where they live and within the affinity groups that they form and call their community.

Within a community, the local health department and community health organizations work to improve health, prolong life, and improve the quality of life among all populations within the community. Local and state health departments are part of the government's efforts to support healthy lifestyles and create supportive environments for health by addressing such issues as sanitation, disease surveillance, environmental risks (e.g., lead or asbestos poisoning), and ecological risks (e.g., destruction of the ozone layer or air and water pollution). The staff at a local health department includes a wide variety of professionals who are responsible for promoting health in the community: public health physicians, nurses, public health educators, community health workers, epidemiologists, sanitarians, and biostatisticians.

Community health organizations have their roots in local community members' health concerns, issues, and problems. These organizations work at the grassroots level, frequently operating a range of health promotion programs for community members. In this text, the term *community health organization* is synonymous with the terms *community agency*, *program*, *initiative*, *human services*, and *project*. Some community health organizations do not choose to use these terms in their names, deciding to use a name that reflects those whom they serve, the health issue they address, or their mission—for example, the American Cancer Society, Caring Place, Compass Mark, Youth Center, Maximizing Adolescent Potentials, Bright Beginnings, Strength and Courage, Healthy Hearts, or Drug Free Youth. Regardless of their names, the common bond for community health organizations is their shared health focus.

Workplaces

Workplaces are anywhere that people are employed—business and industry (small, large, and multinational) as well as governmental offices (local, state, and federal). Workplaces are schools, universities, community-based organizations, and health care organizations. And increasingly it is clear regardless if an organization is for profit or nonprofit, art museum or hospital, it makes financial sense to encourage and support employees' healthy practices. Employers, both on their own initiative and because of the Affordable Care Act and federal regulations administered by the Occupational Safety and Health Administration, have been active in creating healthy and safe workplaces. As employers become aware that behaviors such as smoking, lack of physical activity, and poor nutritional habits adversely affect the health and productivity of their employees, they are providing their employees with a variety of workplace-based health promotion programs. These programs have been shown to improve employee health, increase productivity, and yield a significant value for employers (Fertman, 2015; National Institute for Occupational Safety and Health, 2009).

Stakeholders in Health Promotion Programs

Stakeholders are the people and organizations that have an interest in the health of a specific group or population of people. Stakeholders are people or organizations that have a legitimate interest (a stake) in what kind of health promotion program is implemented. First and foremost are the program participants, also called the *priority population* (for example, students, employees, community members, patients). The program is for their benefit and works to address their health concerns and problems. Although the authors of this book believe that the audience of any health promotion initiative is be regarded as the primary stakeholders, the term *stakeholders* traditionally has referred to other stakeholder groups that also have an interest in a program—for example, top civic, business, or health leaders in the community. The term *stakeholders* may also be used to describe the sponsoring organization's executives, administrators, and supervisors; funding agencies; or government officials. In other words, stakeholders in a health promotion program are people who are directly or indirectly involved in the program.

Involving Stakeholders

Involving the stakeholders in a health promotion program is essential for its success. Involvement creates value and meaning for the stakeholders—for example, enlisting stakeholders to assist in identifying

a program's approaches and strategies in order to ensure congruence with stakeholders' values and beliefs will strengthen stakeholders' commitment to the program. Different stakeholders have different roles. Some stakeholders might help to define what is addressed in a program by sharing their personal health needs and concerns (a process called *needs assessment*, which is discussed in Chapter 4). Other stakeholders might offer services and activities in conjunction with the program (service collaborators). Stakeholders might serve as members of a program's advisory board or as program *champions* or advocates, roles that are often essential in creating successful health promotion programs.

Advisory Boards

Most health promotion programs form some type of *advisory board* or advisory group (also sometimes called a *team*, *task force*, *planning committee*, *coalition*, or *ad hoc committee*) to provide program support, guidance, and oversight. These groups look different across settings. Some are formal, with bylaws, regular meeting schedules, member responsibilities, and budgets. Others are informal, perhaps without any meetings but acting instead as a loose network of individuals who will offer advice and information when called upon by program staff.

Advisory boards play important roles at different points of planning, implementing, and evaluating a program. For example, during planning, advisory board members are involved with determining program priorities as part of the needs assessment, developing program goals and objectives, and selecting program interventions (Chapters 4 and 5). During implementation, they might participate in the initial program offering, program participant recruitment, material development, advocacy, and grant writing (Chapters 6, 7, 8, and 9). During evaluation they often review reports and give feedback on how best to disseminate and use the evaluation results and findings (Chapters 10, 11, and 12).

Who serves as a member of an advisory group? People with a genuine interest in the setting or program and who communicate well with others. Likewise, it is important to have a diverse group of individuals and organizations represented. Always consider the gender, ethnic, socioeconomic, language, and racial composition of the setting, organization, and community when selecting your membership. In addition, things like geographical boundaries, program representation, and community profile are key factors in the selection process.

Champions and Advocates

Health promotion programs often have champions whose advocacy provides leadership and passion for the program. The *champion* typically knows the setting, the health problems, and the individuals, families, and communities affected by the health problem. In the process of planning, implementing, and evaluating a program, champions provide insight into how the organization operates, who will be supportive, and potential challenges to implementing a health promotion program. They know the history of the health problem and what has worked before in solving it as well as what has not worked. (Frequently, champions are also called *key informants* because they know this important or key information about an organization.) Champions are the people who have initiated the effort to start the program, identify the health problem, or try to solve the problem (often volunteering their time and energy). They fight for resources, funding, and space for the program operations. Building a trusting and honest relationship with program champions, advocates, and key informants builds the foundation for the work of planning, implementing, and evaluating a health promotion program.

Health Promotion, Health Care, and eHealth

Health promotion programs exist within an evolving and complex health care system as well as a world of growing health technology. Going forward, changes and decisions made about health care and health technology is expected to impact health promotion programs across the many sites where they operate creating opportunities and challenges.

Today's health care system is dominated by large commercial interests driven by investors' demand for profit, by nonprofits almost equally focused on revenues, and by government policy decisions that are sometimes shaped by larger ideological, political, and budgetary concerns. For better or worse, health care has become big money and big politics. As a result, for the foreseeable future the structure and cost of health care in the United States will continue to be a problem. Over the last few decades health care spending has risen at rapid rates for both the government and the private sector. In 1970, it accounted for 7.2% of the nation's gross domestic product; by 2010, that had increased to 17.9% (Centers for Medicare & Medicaid Services, 2016). Fueling the boom are expensive new drugs and technologies, plus an increase in chronic conditions such as diabetes, asthma, and heart disease, which are costly to treat. Experts also cite unnecessary spending,

with some estimating that 20% or more of total spending is tied to forms of waste, including overtreatment, failure to coordinate a patient's care among providers, and fraud. The consequences are higher costs and lower quality (Berwick & Hackbarth, 2012). Likewise for even the most sophisticated consumer the health care system is overwhelming. In the midst of rapid expansion of medical knowledge intended to benefit many, exists the concern that most individuals do not actually understand medical and health information and cannot navigate the health care system well enough to take advantage of health promotion programs and innovations to improve their health (Koh, 2015; Gawande, 2015).

eHealth is a relatively recent term connected with health promotion and health care practice supported by electronic processes and communication (Table 1.3). Usage of the term varies: some would argue it is interchangeable with health informatics with a broad definition covering electronic/digital processes in health, while others use it in the narrower sense of health care practice using the Internet. It can also include health applications and links on mobile phones, referred to as m-Health. Since about 2011, the increasing recognition of the need for better cybersecurity and regulation may result in the need for these specialized resources to develop safer eHealth solutions that can withstand these growing threats. The term eHealth can encompass a range of services or systems that are at the edge of health, medicine, health care, and information technology.

Table 1.3 What Is eHealth?

What is eHealth? eHealth is the use of digital information and communication technologies to improve people's health and health care. The increasing use of technologies, especially the Internet and mobile devices, to manage health highlights the potential of eHealth tools to improve population health. There are numerous tools and resources that fall under eHealth, including:

- Online communities and support groups
- Online health information
- Online health self-management tools
- Online communication with health care providers
- Online access to personal health records

Why is eHealth important? eHealth tools and resources enable health care consumers and their caregivers to improve health in a number of ways including:

- Real-time monitoring of health vital signs and indicators
- Managing chronic conditions
- Gathering information to make informed medical decisions
- Communicating with health care providers

Source: U.S. DHHS, 2014.

eHealth has the potential to be transformative for promoting the health of individuals, families, and communities. No longer are health promotion programs just at a given site (i.e., school, workplace, hospital) but rather can support individuals' engagement and full participation in promoting their health as well as being decision makers in their health care. eHealth is not limited to a physical place, and therefore health promotion programs are not limited to a particular site. They can and do exist in homes, schools, communities, and workplaces, thereby involving family, colleagues, peers, co-workers, and friends.

Summary

Health promotion programs are the product of deliberate effort and work by many people and organizations to address a health concern in a community, school, health care organization, or workplace. And even though individuals across these sites may share broad categories of health concerns focused on diseases and human behavior, each setting is unique. Effective health promotion programs reflect the individual needs of a priority population as well as their political, social, ethnic, economic, religious, and cultural backgrounds.

Health promotion programs represent an evolution that has passed through three revolutionary steps in the quest to promote health. Today, health promotion programs use both health education and environmental actions to promote good health and quality of life for all. The *Healthy People* initiative is a public-private partnership that allows local health promotion programs to link their health promotion programming with national data and information. Likewise, despite significant legislative and regulatory challenges that have occurred since the law was first enacted in 2010, ACA is moving forward in transforming the health care and health promotion.

Health promotion programs involve stakeholders, advisory boards, champions, and advocates in program planning, implementation, and evaluation in order to ensure effective programming. At the same time the evolution and complexity of the health care system and eHealth create both opportunities and challenges for health promotion programs.

For Practice and Discussion

1. What preliminary ideas did you have about the definition and role of health promotion programs prior to reading this chapter? How do these compare with what you have learned in this chapter?

2. Visit the *Healthy People 2020* website (http://www.healthypeople.gov/HP2020). Pick a chapter and explore the objectives. As you explore the chapter think of your school and how you might use the Healthy People 2020 information for a specific objective to build a case for implementing a health promotion program to address the identified health concern on your campus. Prepare a brief (250-word) statement to use to support your argument for a program.
3. How has the ACA impacted your life and the lives of your family and friends? What ACA provisions promote health? How is the ACA and U.S. health care system related?
4. What do you think it would be like to work in a health promotion program? This chapter talks about health promotion programs in four different settings—schools, workplaces, health care organizations, and communities. Which setting would be of most interest for you in regard to working in a health promotion program? What is attractive about this setting and the people in the setting? Who would be the stakeholders in this setting?
5. What role does technology play in how you, family members, and friends promote your own health? When is the last time you used the Internet to find health information. What wearable health technologies (e.g., personal health devices) and apps do you use?

KEY TERMS

Advisory boards
Champion
Communities
ecological perspective
eHealth
Health
Health care organizations
Health education
Health promotion
Health promotion programs
Health status
Healthy People 2020
Interpersonal level
Intrapersonal level
Jakarta Declaration
Key informant
Lalonde report
Ottawa Charter
Patient Protection and Affordable Care Act or Affordable Care Act (ACA)
Population level

Priority population
Schools
Secondary prevention
Settings
Stakeholders
Social determinants of health
Tertiary prevention
Workplaces
World Health Organization

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