The Future of the Health Education Profession: Implications for Preparation and Practice

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HEALTH EDUCATION has moved rapidly into the limelight during the past decade as an important strategy for improving the nation's health. Along with the rising expectations for health education has come an intensified need to define more clearly the specific competencies of health education specialists and, concomitantly, the educational preparation that they require. Some problems, however, have become evident as the profession of health education has evolved.

During the first two phases of the Role Delineation Project described in this paper (section on "Current Credientialing Efforts"), Dr. Henderson was the director and Ms. McIntosh was an associate. This project, conducted by the National Center for Health Education, San Francisco, was funded by the Health Resources Administration, Department of Health and Human Services, under HRA contracts Nos. 232–78–0154 and 232–80–0014. Dr. Cortese, who during the first phase of the project was director of the Office of Comprehensive School Health, Department of Education, Washington, D.C., is now associate dean of graduate studies, research, and faculty affairs, School of Applied Arts and Sciences, California State University, Long Beach. Dr. Wolle and Dr. Cortese have been members of the Advisory Committee of the Role Delineation Project and of the National Task Force on the Preparation and Practice of Health Educators *(see page 558)*.

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Problems in Health Education

Diversity in preparatory programs and standards. Since the first health education specialist graduated from the Massachusetts Institute of Technology in 1921, the number of bachelor, master, and doctoral level health education programs has increased to at least 252 (*1*). In addition to schools of public health, some of which prepare community health educators, health educators are prepared in 108 bachelor, 83 master, and 31 doctoral level programs. Preparatory programs are found in schools and colleges of education and health as well as in physical education, recreation, and other components of institutions of higher learning. Although there are no uniform guidelines for these programs, they generally prepare health educators for positions in school and community settings.

Lack of a single set of accreditation standards. No single set of accreditation standards applies to all the preparatory programs. For example, those institutions and programs accredited by the Council on Education for Public Health (CEPH) account for the schools of public health (not all of which, however, have health education programs) and also for six graduate programs outside of schools of public health. The National Commission for Accreditation of Teacher Education (NCATE) accredits colleges of education but does not have standards specifically for health education. Again, not all programs not covered by CEPH accreditation are covered by NCATE.

Lack of a single voice for health education. The diversity of preparation for the profession is mirrored in the diversity of national professional organizations concerned with health education, namely, the Association for the Advancement of Health Education (part of the American Alliance for Health, Physical Education, Recreation and Dance), the American School

Health Association, the Public Health Education and School Health Education and Services sections of the American Public Health Association, and the Society for Public Health Education. There are also two national groups of State leaders in health education, the Conference of State and Territorial Directors of Public Health Education and the Society of State Directors of Health, Physical Education, and Recreation. Established in 1972, the Coalition of National Health Education Organizations, which consists of representatives of all the associations mentioned in this paragraph, has begun to address some of the associations' common health education concerns. However, the coalition cannot speak for the entire health education profession; nor can any other single organization.

Uncertainty about qualifications. Because of the lack of specific standards and uniformity in the preparation of health educators, many employers are confused about the role and skills of these professionals. In some areas only graduates of programs accredited by the Council on Education for Public Health are eligible for employment, even though in some instances the requirements for graduation from another program might be more rigid in terms of health education competencies. Actually, because of the lack of standards and definitive competencies, persons without any health education preparation often are made responsible for health education programs.

Lack of manpower data. Although several attempts have been made to answer the manpower questions relating to health educators (*2*), answers have not been forthcoming to such questions as: What is the demand for health educators? How large should the core of health education specialists be? What are health educators prepared to do and why? Where are they practicing? What are the career paths for health educators? What is the current supply of health education manpower?

Lack of quality assurance for consumers. With the increased emphasis on consumer health education (for example, self-help, self-care, holistic health, and health promotion programs) and on the services that are being provided directly to consumers by health educators, it becomes increasingly important that the services rendered by health educators be of high professional quality. Currently, however, there are very few ways of assuring that consumers will receive high-quality health education services.

Today, anyone who so desires may consider himself or herself a "health education specialist." This situation poses identification problems not only for health educators, but also for (*a*) employers who are looking for skilled employees, (*b*) consumers who should be assured of quality services, and (*c*) third-party payers, who are having difficulty discerning what services should be accepted for reimbursement.

Forms of Credentialing

Congress, concerned about effective quality-assurance mechanisms for the burgeoning numbers of new health professions, has passed legislation enabling Federal support for professional activities to set up or revise preparation and practice standards.

Credentialing was defined in 1971 by the Department of Health, Education, and Welfare (now the Department of Health and Human Services) as follows:

> Credentialing of health manpower takes three forms—accreditation of educational programs, certification of personnel by the profession, and licensure by a government agency. The three aspects are closely interrelated and, at times, the terminology is employed interchangeably. State practice acts, establishing the procedures for licensing, usually contain educational requirements. Professional associations, too, usually require that the applicant satisfy certain educational qualifications. For purposes of clarity, the following definitions are presented.
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> Accreditation—The process by which an agency or organization evaluates and recognizes an institution or program of study as meeting certain predetermined criteria or standards.
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> Licensure—The process by which an agency of government grants permission to persons to engage in a given profession or occupation by certifying that those licensed have attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected.
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> Certification or registration—The process by which a nongovernment agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association. Such qualifications may include: (*a*) graduation from an accredited or approved program; (*b*) acceptable performance on a qualifying examination or series of examinations; and/or (*c*) completion of a given amount of work experience.

Some parts of the credentialing mechanisms for health education are already in place, but are not adequately implemented or sufficiently comprehensive. Each mechanism presents complexities for the profession and reflects the mechanism's relationship to contemporary health manpower issues. For example, in 1971, because of the overwhelming proliferation of requests for licensure, the Federal Government called for a 2-year moratorium, which was subsequently extended for another 2 years, on licensure of new health professions (*3*).

Health educators have an opportunity to consider the various forms of credentialing and to choose those that will help meet the expectations being thrust upon the profession. The multiple and overlapping rela-

tionships of the credentialing mechanisms accentuate the intimate relationship between preparation for the profession and its practice. Some health educators are academically prepared but cannot perform the tasks that their role requires. Conversely, some who do not have the preparation deemed necessary for quality practice can perform well. For these reasons, many believe that assurance of competency through credentialing must take more than one form.

Accreditation of Programs

Accreditation offers a means to establish basic standards for preparation. Currently, there is no national accreditation mechanism for most institutions that prepare health educators. Aside from regional accrediting bodies, such as the North Central Association of Schools and Colleges, CEPH and NCATE accredit schools of public health and colleges of education. Because CEPH and NCATE, however, generally focus on institutional accreditation, there is a lack of emphasis on the evaluation of individual preparatory programs within institutions. In contrast, a health education program outside of a school of public health that seeks to be accredited by CEPH must meet standards beyond those required of its counterpart in a school of public health. This difference in accreditation requirements is an issue that must be resolved.

Several factors must be considered in the accreditation of health education preparatory programs as one aspect of a credentialing system. First, as previously stated, the existing accrediting agencies do not encompass the entire spectrum of programs in institutions that prepare health educators. Second, criteria that can be used as a basis for accreditation do not exist, although they are being formulated. Third, the trend toward accreditation of institutions and away from accreditation of programs will require health educators to work closely with the existing accrediting agencies. Fourth, personnel in professional preparatory programs need to establish common goals and some basic standards for preparation that will meet the expectations of public policymakers, employers, third-party payers, educational support agencies, and above all, the public.

Credentialing of Individuals

Although accreditation can serve as a useful method of credentialing, attention should be directed also to the credentialing of individuals by licensure, certification, or registration. Licensure has been the form of credentialing selected by many health professions, but it can be unwieldy. As a State-level function, licensure requires that individual States enact legislation to create such licensure, to establish and appoint governing boards, and to maintain a staff for preparing, administering, and revising licensing examinations. When necessary, provision also has to be made for relicensure, for the investigation of applicants' credentials and of complaints from the public about individual practitioners, and for disciplining those who violate licensure standards.

Several other factors make licensing a difficult procedure for practitioners, the State, and the public. Varying licensure standards restrict the mobility of licensed professionals. Separate licensing boards often result in duplicative bureaucracies, which add to costs and have prompted some States to consolidate licensing boards. The desirability of licensure for life, in the light of the rapid changes in the health field, is questionable. Also, members of established health professions often resist new categories of licensure, since they may perceive the new professions as encompassing part of their own practice base.

For health education, certification currently represents the most feasible route for credentialing individuals. For this method of credentialing, an independent nonprofit agency is needed to prepare and administer an examination that is based upon the skills and knowledge necessary for competent performance of the professional's role. Certification can be tied to continued competency through continuing education and periodic recertification. Since certification is generally national in scope, it allows certified practitioners mobility. The frequent use by third-party payers of certification as a standard for determining reimbursement for services rendered affects the certified practitioner's employment opportunities.

From a legal perspective, certification can be either mandatory or voluntary. When mandatory, it acts in much the same way as licensure, in that only those who are certified can practice. Since many health educators are employed by government agencies, public policymakers may make certification mandatory for employment in the public sector. As a voluntary mechanism, certification provides employers with descriptions of the capabilities of certified persons. In turn, through voluntary certification, the public is able to identify qualified practitioners.

Implementing credentialing procedures that include accreditation and certification will require action in two domains. First, the institutions preparing health educators should convene to review and analyze the current status of credentialing, especially accreditation, and then formulate an appropriate plan of action. Second, individual health educators should be informed about

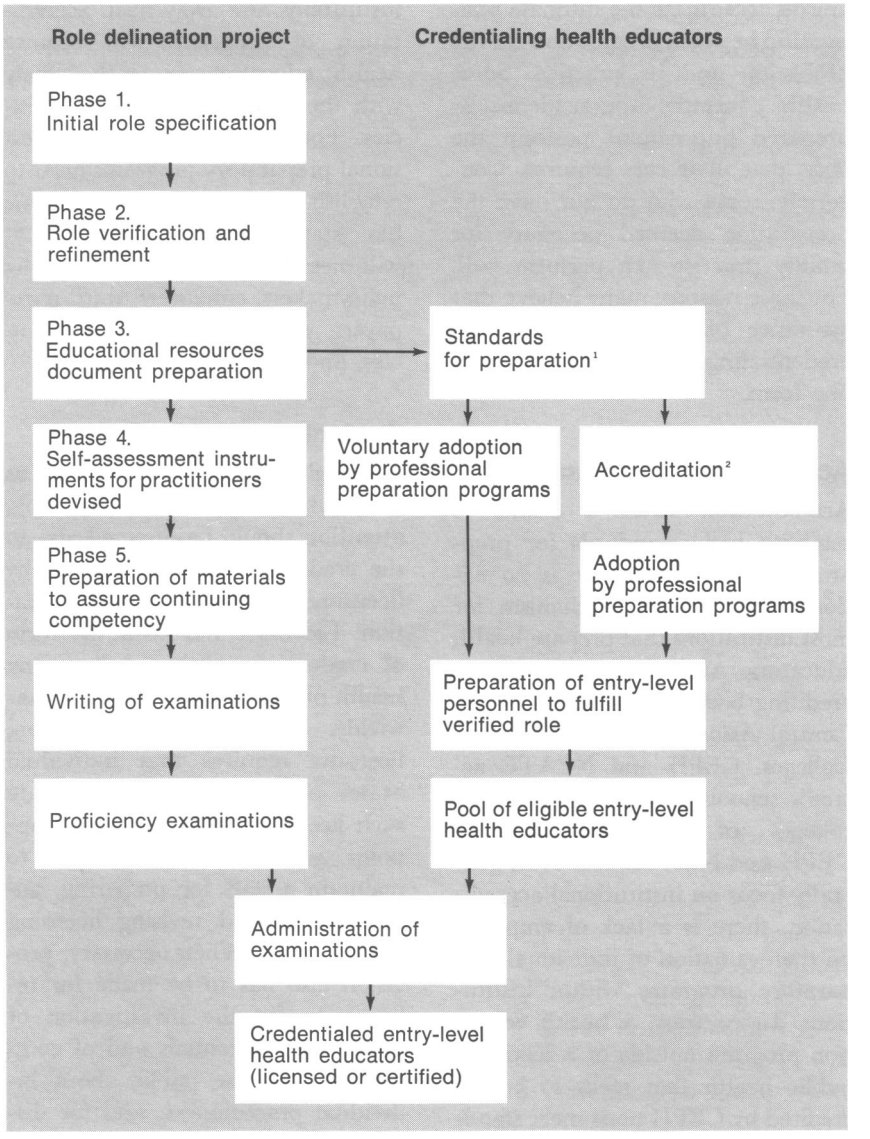
credentialing issues, so that through the leaders of their professional organizations, they can help devise a feasible plan for implementing certification procedures. Within that plan, provision needs to be made for (*a*) preparing certification examinations that accurately reflect the role of health educators and (*b*) identifying an existing organization, or creating a new one, capable of administering the certification process.

Current Credentialing Efforts

The Bureau of Health Professions, Health Resources Administration (Department of Health, Education, and Welfare) sponsored a conference in February 1978, which was attended by 40 health educators from across the nation. The conferees explored the commonalities and differences in the preparation and practice of health educators in school, community, and medical care settings (*4*). The committee that planned this conference subsequently became the National Task Force on the Preparation and Practice of Health Educators, which was charged with the responsibility for formulating a plan for credentialing health educators.

Under a contract with the National Center for Health Education, San Francisco, a role delineation study for health education was successfully pursued. In this study, staff of the Role Delineation Project followed a credentialing plan set up by the Division of Associated Health Professions of the Bureau of Health Professions. This plan, which could lead to establishment of a system of credentialing for a profession, includes the following seven steps: initial role delineation, verification of role(s), preparation of an educational resource document, devising criterion-referenced self-assessment instruments for practitioners, preparation of continuing education materials, writing proficiency examinations, and devising means for validation of such examinations.

Relationship between role delineation and credentialing processes



[1] Endorsed by Association for the Advancement of Health Education, American College Health Association, American Public Health Association, American School Health Association, Society of Public Health Educators, Society of State Directors of Health, Physical Education, and Recreation, and Conference of State and Territorial Directors of Public Health Education.

[2] For example, by Council on Education, National Commission for Accreditation of Teacher Education for Public Health, North Central Association of Schools and Colleges, and State teacher credentialing authorities.

The first phase of the work was completed in January 1980. The basic professional skills of entry-level health education practitioners were identified in the initial role delineation process. Entry level was tentatively defined as the baccalaureate level or its experiential equivalent. The second phase of the project also has been completed, in which role delineation was tested in the field to determine if, in fact, the preliminary description arrived at in the first phase was accurate and complete. (A report presenting the results of this testing will be available at a later date.)

From the initial efforts to deline-

ate the role of the professional health educator has emerged the concept of a generic, or common, role for all health educators regardless of their work settings. In the initial role delineation—which was based upon the hypothesis that a common role does exist—seven major areas of responsibility of the entry-level health educator were delineated (*5*) :

The entry-level health educator, working with individuals, groups, and organizations is responsible for:
- . . . communicating health and health education needs, concerns, and resources.
- . . . determining the appropriate focus for health education.
- . . . planning health education programs in response to identified needs.
- . . . implementing planned health education programs.
- . . . evaluating health education.
- . . . coordinating health education activities.
- . . . acting as a resource for health information and health education.

These areas of responsibility, along with the respective functions and the required skills and knowledge, have been tested against the variety of educational and experiential backgrounds of actual health education practitioners. Through role-refinement and role-verification processes, the existence of the generic role was also tested.

Although the process of role delineation is described here sequentially, the sequence given need not be strictly followed. Once the role has been refined and verified, proficiency examinations can be prepared. However, to assure that an eligible pool of health educators has been prepared to meet the role delineated, adherence to the stated sequences has merit. The relationship between role delineation and the construction of credentialing mechanisms is depicted in the chart.

Conclusion

A systematic approach to defining the role of the health education specialist can provide a sound basis for establishment of health education standards that will improve both the preparation and practice of health educators. Accreditation of preparatory programs and certification of individuals can serve as complementary credentialing mechanisms that will benefit employers, consumers, and health educators. With governmental support for the delineation of the health educator's role, steps are now being taken to explore and resolve the significant issues affecting the professional preparation and practice of health educators. By focusing on improving the quality of the services they provide, health educators are moving toward fullfillment of the currently heightened expectation for health education as an effective strategy for improving the nation's health.

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SYNOPSIS

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The health education profession has come to a critical point in its development. If health education is to fulfill its promise as a worthwhile strategy to improve health, the specific competencies of health education specialists and, concomitantly, the educational preparation that they need must be clearly defined. In the past, no clear definition was possible because of the diversity of preparatory programs, the absence of commonly accepted accreditation standards, the lack of a single voice for health educators, inconsistent employment requirements, inadequate manpower data, and poor mechanisms for quality assurance.

Health educators are examining the various forms of credentialing—accreditation, licensure, and certification—with a view to their use as a means of strengthening the profession's preparation and practice standards. A Role Delineation Project undertaken by the National Center for Health Education, San Francisco, under a contract with the Bureau of Health Professions of the Health Resources Administration, has been completed. Activities that will be carried out subsequent to role delineation are expected to enable the health profession to resolve systematically fundamental issues in respect to manpower standards.