Competency Focused versus Philosophically Grounded Health Promotion Practice: Impacts on Innovation and Addressing Health Inequities

Tyler G. James, Ph.D., CHES®[1], Meagan K. Sullivan, M.P.H., CPH, Heather Henderson, Ed.D.[2], & Julia R. Varnes, Ph.D., M.P.H., MCHES®[3]

Affiliations:

1. Department of Family Medicine, University of Michigan, Ann Arbor, MI, USA.
2. Department of Health Policy, Management, and Leadership, West Virginia University, Morgantown, WV, USA.
3. Department of Health Services Research, Management, and Policy, University of Florida, Gainesville, FL, USA.

Conflicts of Interest: TGJ and HH are members of the Editorial Board for *Pedagogy in Health Promotion*. JRV serves on the National Commission for Health Education Credentialing's Division Board for Certification of Health Education Specialist (DBCHES), which develops the CHES and MCHES exams. TGJ has also served as a Subject Matter Expert for DBCHES. The perspectives and opinions expressed in this paper are those of the authors and do not intend to represent the positions of *Pedagogy in Health Promotion*, the Society for Public Health Education, or the National Commission for Health Education Credentialing.

Acknowledgements: The authors thank Dr. Lisa Yazel, Mr. Devon K. Mims, the editor, and anonymous reviewers for feedback and constructive criticism on early drafts of the manuscript.

Abstract

The professionalization of the fields of health education and health promotion has largely coincided with the completion of job task analysis conducted by major organizations in the field (e.g., the National Commission for Health Education Credentialing, Society for Public Health Education). The process through which these job task analyses and skill-based competencies are implemented in professional preparation programs poses a risk to stifle advancement and innovation in health education and promotion. In this perspective, we discuss Competency Focused Practice (the current state of the field) to a goal of Philosophically Grounded Practice. We provide comparisons of the implications of these two schools of thought with respect to ethics, social determinants of health, and practical methods in health education and promotion.

Competency Focused versus Philosophically Grounded Health Promotion Practice: Impacts on Innovation and Addressing Health Inequities

In a graduate-level course, *Principles and Philosophies of Health Education*, an established leader in health education asked students: "What is the purpose of health education?" On more than one occasion, a student would eagerly raise their hand and respond, "To implement policies and programs to reduce health disparities." Several students nod, unequivocally supporting the student's description. The instructor then sets out each year to revise this definition of health education and promotion (HE/P) and encourages students to ask thought-provoking questions of the methods, techniques, and reason behind our practice; that is, the instructor was encouraging us to think philosophically about HE/P.

Over 35 years ago, the Ottawa Charter for Health Promotion was adopted, highlighting the role of health promotion practitioners in advocating for health equity and social justice (First International Conference on Health Promotion, 1986). The adoption of the charter coincided with the start of the professionalization of the field of HE/P.[1] The National Commission for Health Education Credentialing (NCHEC) has credentialed thousands of professionals as Certified and Master Certified Health Education Specialists (CHES/MCHES) over the past three decades.[2] The backbone of this professionalization has been five practice/job task analyses sponsored by NCHEC and the Society for Public Health Education (SOPHE). Briefly, these analyses have been implemented by: (1) engaging HE/P experts to develop a survey to assess the importance,

[1] We use the term health education and promotion (HE/P) to be inclusive of both the field of health education and health promotion. Readers should be aware of the differing philosophical underpinnings of these two professions. For more information, we point readers to Wallerstein and Bernstein (1988) and *Philosophical Foundations of Health* Education (Black et al., 2010).

[2] Although the professionalization of the field has occurred internationally (e.g., the International Union for Health Education and Promotion's accreditation system), the focus of this article is on the U.S. context. Unquestionably, this professionalization has improved the credibility of HE/P practice, leading to improvements in recognition by government agencies (e.g., U.S. Bureau of Labor Statistics) and efforts to receive insurance reimbursement for HE/P specialists working in healthcare settings, and aligning with Healthy People 2030.

frequency, and performance expectation of competencies; (2) administering the survey to HE/P practitioners; (3) revising the competencies; and (4) releasing a new competency-based framework. The most recent analysis, the Health Education Specialist Practice Analysis II (HESPA II), outlines eight Areas of Responsibility for practicing HE/P specialists (NCHEC & SOPHE, 2020). The revised competencies are then implemented in HE/P professional preparation programs to realign curriculum to the job task analysis. Through this process, Competency Focused Practice (CFP) emerges.

It is through the maintenance of CFP, specifically how institutions of higher education implement curriculum aligned to the competencies, that we believe institutions seek to teach-to-the-test, restricting innovation and advancement in the field and, more importantly, limiting practitioners in thinking about systems that are root causes to health inequities. When the focus is on teaching practice-based skills, to the point of excluding opportunities for students to develop philosophical and critical thinking related to our approaches, we are at risk of becoming professionals who: (1) think the goal of HE/P is to solely reduce health inequities, instead of recognizing that *health is not the outcome of interest, it is a means to a higher quality of life* (First International Conference on Health Promotion, 1986; Green & Kreuter, 2005, pp. 32–34); (2) fail to connect foundational work in the field to current practice (e.g., social justice; First International Conference on Health Promotion, 1986); and, (3) are unable to critically defend decisions to use specific methods and materials outside of what has been identified as evidence-based practice, the singular use of which promotes the false notion of neutrality in science (Mertens, 2007).[3]

[3] Of note, the 2020 Joint Committee on Health Education and Promotion Terminology indicated the recognition of a new term of evidence-informed practices which is "the use of practice-based knowledge, coupled with the best available research and evaluation results" (Videto & Dennis, 2021, pp. 10–11). The

While we believe that the HE/P profession requires competency-based skills to develop shared language and systematically address health disparities, there is an underlying need to enhance competency-based training with philosophical underpinnings of HE/P practice. Unquestionably, the HESPA II framework provides a thorough introduction to skills *necessary* (but perhaps not sufficient) for a HE/P practitioner. Students and practitioners should be encouraged to identify and develop their worldview and philosophical orientation. Without this encouragement, innovation and advancement in the field will be stifled and students/practitioners may assume a nonphilosophic stance due to ignorance. Instead, we call for "Philosophically Grounded Practice" which encourages academic programs to assist students in developing philosophical thinking in addition to teaching skills-based competencies necessary for practice. Through this process, students and early-career HE/P specialists will learn the philosophical underpinnings of HE/P, engage in ethical decision making, and critically assess the use of certain methods that may be at odds with the historic lens of HE/P.

Example Comparisons Between Competency Focused Practice and Philosophically Grounded Practice

Ethics

Within the HESPA II framework (NCHEC & SOPHE, 2020), Competency 8.1 is the sole ethics-focused competency (of 35). Having a stand-alone ethics competency is different from previous frameworks, which placed ethics sub-competencies under specific areas. Although this change emphasizes the importance of ethics in HE/P, it assumes ethics is a practical skill and not an antecedent that influences all practice. This is further demonstrated in related sub-competencies, which focus on applying professional codes of ethics and complying with legal

---

movement from evidence-based to evidence-informed practice is also introduced in NCHEC and SOPHE's HESPA II, but little evidence describes how this is implemented in curricula.

standards and regulatory guidelines. Within a CFP, these sub-competencies may encourage uncompromising ethical decision-making and lead to the conclusion that ethics should be primarily informed by legal standards. A Philosophically Grounded Practice, in contrast, would encourage students and practitioners to understand the scope of regulations and apply ethical decision-making in indistinctive areas.[4]

To expand this idea further, in CFP, HE/P practitioners may only consider the regulatory guidance on individual risk-benefit (NCHEC & SOPHE, 2020). A Philosophically Grounded Practice, however, would seek to understand the larger risk-benefit of research and evaluation outside of interventions and data collection. Mertens's (2007) Transformative Paradigm, which shares philosophical roots with the field of HE/P, would encourage practitioners to understand the ethical risks to *communities* at each level of study/evaluation design and reporting.

Appropriate Conceptualizations: Social Determinants of Health or Fundamental Causes

Within public health and HE/P, there is longstanding support that social factors/social determinants of health influence health (Harvey, 2020). These factors may include socio-economic position, food security, environmental quality, and access to education. Additionally, Healthy People 2030 identifies racism as a social determinant of health (U.S. Department of Health and Human Services, 2020). Under CFP, which would seek to align HE/P practice with Healthy People 2030 and other government-promoted best practices, racism is conceptualized as a social determinant of health alongside income or housing quality. This conceptualization is incomplete. A Philosophically Grounded Practice would seek to interrogate the role of racism in society and in health and, in doing so, would critically apply fundamental cause theory (Link &

[4] As described here, ethics should not be viewed as just a skill, such as determining an evaluation design. Ethical thinking is a process that influences methods, processes, and interpretation within practice. Still, we support the inclusion of ethics as a primary responsibility within the HESPA II framework.

Phelan, 1995; Phelan & Link, 2015). Under the theory of fundamental causes, racism is a system of power/oppression that is causal to disparities across multiple social determinants of health (e.g., socioeconomic position, housing quality). Unlike other social determinants of health (e.g., housing quality), racism is not merely an exposure – it is a far-reaching system of exposure (Riley, 2020). Plainly, racism is a determinant of the social determinants (Bailey et al., 2017; Phelan & Link, 2015). We arrive to this same conclusion when applying other social theories, such as ecosocial theory from social epidemiology: racial discrimination has major pathways to exposure to hazardous environmental toxins and economic and social deprivation, all forms of social determinants (Krieger, 2012).

However, due to CFP's dominance in preprofessional training programs and focus on behavioral theory, social theory (such as theory of fundamental causes and ecosocial theory) is not frequently taught (Harvey, 2020). This lack of education may lead to a lack of appropriate conceptualization of social determinants of health, by ignoring – and not naming – the structural, fundamental causes that are responsible for the distribution of those social determinants. Under a Philosophically Grounded Practice, social theory – inextricably linked to philosophical paradigms – would be taught, enabling health education specialists to apply these theories in practice.

Defending the Use of Specific Methods and Materials

Within CFP, a method may be used based on the empirical or theoretical evidence that it will effectively change behavior as CFP seeks to employ evidence-based practice [i.e., "systematically identifying, appraising, and using valid and reliable research and evaluation results to guide development, planning, implementation, and evaluation of health education and promotion programs and policies" (Videto & Dennis, 2021, p. 10)]. A CFP would call for a HE/P

specialist to apply evidence-based practices solely due to the evidence-based nature; however, this assumes the use of these practices are not attached to a philosophy, and, in light of supporting empirical evidence, all practices should be given equal consideration.

A core tenet of the traditional philosophy of health education is to inform and encourage and respect freedom of choice (American Association for Health Education, 2005; Black et al., 2010). This tenet is based on the belief that individuals must be given the opportunity and choice to believe certain information and determine their own behavior (American Association for Health Education, 2005). A Philosophically Grounded Practice, in accordance with the code of ethics of the profession (see Section 4; Coalition of National Health Education Organizations, 2020), would require a clear rationale for methods used. This would include an interrogation of the philosophical assumptions of those methods, and if these assumptions align with the needs of communities and individuals or the philosophy of a program. To be clear, we are not seeking the sole promotion of the traditional health education philosophy. Instead, we seek to ensure that students and practitioners are aware of the philosophical assumptions inherent in the methods they use and are encouraged to critically consider the assumptions inherent in the methods they will use.

For example, consider the use of behavioral economics or nudge theory in HE/P practice which is being promoted in textbooks (e.g., Glanz et al., 2015) and program demonstrations (e.g., Leonard et al., 2013). Behavioral economics' underpinning philosophy is described as "asymmetric paternalism" (Volpp et al., 2015) or "libertarian paternalism" (Thaler & Sunstein, 2009). These philosophies are described as "protecting people from themselves" without "restricting freedom of choice" (Volpp et al., 2015, p. 393) by promoting a specific choice in lieu of other choices. In HE/P, this technique may be called "choice architecture" or "nudges." For

example, a HE/P specialist using behavioral economics in a school cafeteria setting may establish programs to serve only a 'healthy' entrée unless another option is requested. Choice architecture and other behavioral economic approaches have an evidence-base indicating effectiveness in some settings, for some health problems, and in some populations (Glanz et al., 2015). A CFP would defend the utility of behavior economics with this evidence-base, while a Philosophically Grounded Practice would look at both the evidence-base and the philosophical alignment of these methods with the program.

Conclusion

In this perspective, we have sought to open the metaphorical black box of Competency Focused Practice and have briefly emphasized the importance of Philosophically Grounded Practice from which the competencies can be taught. The professionalization of the field of HE/P has largely been catalyzed through the job task analyses (e.g., HESPA II), and the use of derived competencies for accreditation and credentialing. However, the implementation of the competencies in HE/P preparation programs, without providing additional training in philosophical, ethical, and critical thinking, may hinder advancement and innovation in the field. Philosophical foundations of education have shaped not only the methods we use to teach, but also have shaped the purpose for which we teach. The very competencies with which we evaluate our programs come from a tradition steeped in a desire to focus on the teaching of skills with the intent to manage problems in the real world (Bloom et al., 1956). While developing skills is important, practitioners need to understand when best to apply those skills. Exposing students and professionals to a variety of philosophical paradigms and frameworks provides a foundational understanding of when to use certain strategies. Idealism provides methods to encourage our students to focus on what makes us good (e.g., James et al., 2020); realism

provides methods to help us understand our material world (e.g., Greece et al., 2019); pragmatism uses techniques to help us understand life itself (e.g., Hemingway et al., 2020); behaviorism gives us the tools to make positive changes in our actions (e.g., Gainforth et al., 2021); phenomenology gives us the space to create learners that are perceptive and open to possibilities; constructivism provides techniques for actively involving students in the process of developing meaning and knowledge (e.g., Hunt et al., 2020); and so on (Ozmon, 2011). Philosophical perspectives and ethical thinking appropriately enable students and professionals to identify and critique systems of power and oppression impacting health behavior and health outcomes. Understanding our own philosophical assumptions and orientations and those of the people we are serving will help us to more effectively communicate as HE/P specialists.

Therefore, our top recommendation is that preparation programs introduce students and professionals to the variety of philosophical paradigms and ethical frameworks relevant to HE/P while encouraging students to identify and critique paradigms and systems of power and oppression which influence HE/P practice. This can be done through a lecturer course, seminar course, or directed readings. We eagerly await publications that describe how philosophy is taught in HE/P preparation programs, and how this teaching is critical for addressing health inequities.

References

American Association for Health Education. (2005). *Philosophy of health education: An AAHE position statement* (p. 6).

Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: Evidence and interventions. *Lancet (London, England)*, *389*(10077), 1453–1463. https://doi.org/10.1016/S0140-6736(17)30569-X

Black, J. M., Furney, S., Graf, H. M., & Nolte, A. E. (Eds.). (2010). *Philosophical foundations of health education*. Jossey-Bass.

Bloom, B. S., Engelhart, M. D., Furst, E. J., Hill, W. H., & Krathwohl, D. R. (1956). *Taxonomy of educational objectivties: The classification of educational goals. Handbook I: Cognitive domain.* David McKay Copany.

Coalition of National Health Education Organizations. (2020). *Code of ethics for the health education profession*. http://cnheo.org/code-of-ethics.html

First International Conference on Health Promotion. (1986). *Ottawa Charter for Health Promotion*. World Health Organization. https://www.euro.who.int/__data/assets/pdf_file/0004/129532/Ottawa_Charter.pdf

Gainforth, H. L., Dineen, T. E., Giroux, E. E., & Forneris, T. (2021). Teaching behavior change theory in Canada: Establishing consesus on behavior change theories that are recommended to be taught to undergradaute students in courses addressing behavior change. *Pedagogy in Health Promotion*, *7*(1), 51–59. https://doi.org/10/ghnn53

Glanz, K., Rimer, B. K., & Viswanath, K. (2015). *Health behavior: Theory, research, and practice*. John Wiley & Sons.

Greece, J. A., DeJong, W., Gorenstein Schonfeld, J., Sun, M., & McGrath, D. (2019). Practice-based teaching and public health training: Brining real-world projects to the classroom to teach intervention planning and communication strategies. *Pedagogy in Health Promotion*, *5*(1), 55–61. https://doi.org/10/gnqmpz

Green, L. W., & Kreuter, M. (2005). *Health program planning: An educational and ecological approach.* (4th ed.). McGraw-Hill.

Harvey, M. (2020). How do we explain the social, political, and economic determinants of health? A call for the inclusion of social theories of health inequality within U.S.-based public health pedagogy. *Pedagogy in Health Promotion*, *6*(4), 246–252. https://doi.org/10.1177/2373379920937719

Hemingway, B. L., Felicitas-Perkins, J. Q., Johnson, C. A., Osur, M., Peterson, D. V., Orr, J., & Gatto, N. M. (2020). Learning through practice: The design and implementation of an advanced integrative practicum for DrPH students. *Pedagogy in Health Promotion*, 2373379920931896. https://doi.org/10/gnqmp3

Hunt, L., Tkach, N., Kaushansky, L., & Benz Scott, L. (2020). Analysis of an interprofessional experiental learning program utilizing the case of Henrietta Lacks. *Pedagogy in Health Promotion*, *6*(3), 203–211. https://doi.org/10/gmzcx8

James, T. G., Sullivan, M. K., & Varnes, J. R. (2020). Improving representation of people with disabilities in health education. *Pedagogy in Health Promotion*, 2373379920978822. https://doi.org/10.1177/2373379920978822

Krieger, N. (2012). Methods for the scientific study of discrimination and health: An ecosocial approach. *American Journal of Public Health*, *102*(5), 936–944. https://doi.org/10.2105/AJPH.2011.300544

Leonard, T., Shuval, K., de Oliveira, A., Skinner, C. S., Eckel, C., & Murdoch, J. C. (2013). Health behavior and behavioral economics: Economic preferences and physical activity stages of chagne in a low-income African-American community. *American Journal of Health Promotion*, *27*(4), 211–221. https://doi.org/10.4278/ajhp.110624-QUAN-264

Link, B. G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior*, 80–94. JSTOR. https://doi.org/10.2307/2626958

Mertens, D. M. (2007). Transformative considerations: Inclusion and social justice. *American Journal of Evaluation*, *28*(1), 86–90. https://doi.org/10.1177/1098214006298058

National Commission for Health Education Credentialing, Inc. & Society for Public Health Education, Inc. (2020). *A competency-based framework for health education specialists—2020.*

Ozmon, H. (2011). *Philosophical foundations of education* (9th ed.). Pearson.

Phelan, J. C., & Link, B. G. (2015). Is racism a fundamental cause of inequalities in health? *Annual Review of Sociology*, *41*(1), 311–330. https://doi.org/10.1146/annurev-soc-073014-112305

Riley, A. R. (2020). Advancing the study of health inequality: Fundamental causes as systems of exposure. *SSM - Population Health*, *10*, 100555. https://doi.org/10.1016/j.ssmph.2020.100555

Thaler, R. H., & Sunstein, C. R. (2009). *Nudge: Improving decisions about health, wealth, and happiness* (Revised&Expanded edition). Penguin Books.

U.S. Department of Health and Human Services. (2020). *Healthy People 2030 Objectives*. HealthyPeople.Gov. https://health.gov/healthypeople/objectives-and-data/browse-objectives

Videto, D. M., & Dennis, D. L. (2021). Report of the 2020 Joint Commission on Health Education and Promotion Terminology. *The Health Educator*, *53*(1), 4–21.

Volpp, K., Loewenstein, G., & Asch, D. (2015). Behavioral economics and health. In K. Glanz, B. K. Rimer, & K. Viswanath (Eds.), *Health behavior: Theory, research, and practice* (5th ed., pp. 389–409). Jossey-Bass.

Wallerstein, N., & Bernstein, E. (1988). Empowerment education: Freire's ideas adapted to health education. *Healthy Education Quarterly*, *15*(4), 379–394. https://doi.org/10.1177/109019818801500402