Health promotion or ‘wellness’?
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The expression ‘wellness’ has an unfamiliar sound to UK readers, but its use in highlighting a particular philosophy of health education deserves wider currency. However, is there a fundamental distinction between the concepts of ‘illness-proofing’ on the one hand and wellness or ‘enabling’ health education on the other? Or do they just represent different stages on the same ladder?

A review of 24 issues of Education and Health finds little mention of ‘wellness’, well-being or the wellness movement. This suggests that the movement is not yet well established in the United Kingdom. Assuming that this will change, this article is intended to serve as an introduction.

Wellness, as it is observed by this writer, is a process intended to improve individuals’ status in specific areas of structure and function. Wellness professionals, operating out of centres in hospitals, factories, or universities, develop and implement programmes to improve body composition, cardiovascular endurance, smoking cessation, dietary practices, and stress management. These programmes utilize a number of approaches in fostering improvement, including health education, counselling, and participant involvement in a variety of risk-reducing activities. These programmes can be found in a variety of settings, including educational institutions, hospitals, health maintenance organizations, and an array of work sites. The professionals who staff these programmes are trained in areas such as exercise science, health education, dietetics, counselling, psychology, and business management. Graduate-level programmes in wellness management are now offered in two American universities.

A wider variety of people participate in wellness programmes. Participants include students, employees of corporations and institutions, and persons whose involvement has been ordered by their physicians. The observable outcome of their involvement is a leaner body, better cardiovascular function, freedom from smoking, improved eating patterns, and more effective approaches to stress management. Participants are told that involvement in these programmes will result in enhanced life satisfaction, or, as it is referred to by wellness professionals, a sense of well-being. Corporations that have wellness programmes anticipate lower use by employees of group health insurance, greater job productivity, and enhanced employee morale.

To this writer, the most interesting aspect of the wellness movement in the United States has been its ability to market itself as being significantly differ-
ent from the health promotion movement and health promotion programmes that have existed for decades. This differentiation appears to be based on the movement's success in presenting health promotion as 'reactive' in the sense that it only seeks to avoid illness. Health promotion, according to wellness professionals, is only interested in a leaner body as a means of forestalling obesity; cardiovascular conditioning as a means of preventing heart disease; smoking cessation as a means of preventing lung cancer; improved dietary patterns as a means of preventing malnutrition, and stress management as a means of preventing psychosomatic illnesses. Accordingly, high-level health (the outcome of health promotion) is, at best, a state of being 'illness-proofed'. In comparison with health promotion, wellness is presented by its advocates as being 'proactive', largely unconcerned about illness, and dedicated to moving participants in the direction of increased life satisfaction.

If on the basis of this description, you are confused as to whether a difference really exists between wellness and health promotion, you can be comforted by the fact that a number of health professionals in the United States appear similarly confused. To be certain, the 'reactive' versus 'proactive' explanation is attractive. Yet, when the processes used by both groups are compared, the similarities in approach lead one to question how different outcomes can be achieved.

This writer is particularly troubled as he observes that the wellness movement provides little direction for participants regarding the application of their improved structure and function. Without knowing what is to be accomplished more easily or more completely as a result of having undergone wellness training, how will participants recognize their newly-achieved state of well-being? What will participants have to feel better about, having undergone a wellness programme, than the reduced morbidity and mortality that would also be associated with health promotion and 'high-level health'?

Professionals who believe that wellness could become 'proactive', and substantively different from health promotion, await evidence that wellness professionals are focusing on the contributions that their training can make to the growth and development of participants in areas related to intimacy, parenting, community involvement, and employment. So long as the only (or primary) concern of the wellness movement is with improved structure and physiological function and altered risk behaviours, its claim to be 'proactive' and different from health promotion will remain largely semantic.

Note
1. Graduate level programmes in wellness now offered in American universities include:
   - American University, Washington, DC: Health/Fitness Management (1979)
   - Ball State University, Muncie, Indiana: Wellness Management (1988)

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A 5-year national programme to reduce smoking by teenagers

The autumn of 1989 will see the national launch of a 5-year HEA programme to reduce the prevalence of smoking amongst teenagers, especially girls.

Its targets are well-defined, and in the discussion document the major ones have been presented as follows:

By November 1994...
1. Prevalence of regular smoking in England among 11-15 year olds, as measured by a survey comparable to the 1986 OFCS study, should be 5% for both boys and girls. (The 1986 OFCS study...)

1 Purpose
1.1 The purpose of this paper is to present for consultation, proposals for a five year national programme to reduce the prevalence of smoking among teenagers, especially girls, in England.

1.2 It is intended that the national programme, to be launched in 1989, will:
   - build on the existing activities of LEAs, HASs, LAs, and other organisations active in this important field of public health.
   - be coordinated by the Health Education Authority (HEA) with the Department of Health and the Department of Education and Science, in collaboration with LEAs, HASs, LAs, ASH, TACADE, major health charities, and other voluntary bodies, and the other UK national health promotion agencies, as appropriate.
   - become recognised as a national initiative, jointly planned with all participating local and national organisations, as far as possible.

1.3 The proposed programme will consist of three major activities, each of which will be mutually reinforcing:
   - provision of support to schools, LEAs, and HASs etc for the continued development of effective curricular and related strategies.
   - development of major mass media and publicity campaigns to influence children's smoking, and to enlist the support of the public, especially parents.
   - conduct of a major programme of research to inform and assist the development and planning of the programme and its activities, and to monitor its continuing progress and outcomes.

1.4 The above strategies will be constantly reviewed and modified in the light of consultation, research and evaluation as the programme develops.

1.5 This paper summarises the proposed rationale, aims, objectives, major activities and outline timetable for the campaign. It is accompanied by the following annexes:
   - Annex A Proposed targets - p.3
   - Annex B Current HEA activities related to the prevention of teenage smoking - p.4
   - Annex C Details of proposed national programme and resources required - p.5
   - Annex D References - p.8

2 Rationale
2.1 Smoking remains by far the major preventable cause of death in the UK, responsible for at least 100,000 premature deaths annually from lung cancer, coronary heart disease, bronchitis, emphysema, etc(6). Treatment costs to the National Health Service are estimated at £500 million annually(6).

2.2 In children, smoking leads to impaired development of the lungs, and early signs of damage to major blood vessels.

2.3 At present, the majority of smokers take up regular smoking before the age of 16. In 1986, 18% of boys and 27% of girls were regular smokers at age 15(6).

2.4 Key target age group. Following the recent recommendations of two international expert panels(7,8), the programme's major aim will be to assist in providing non-smoking 11-13 year olds with the knowledge, motivation and skills to resist the pressures to smoke. It is proposed that special attention will be paid to the year following transfer to secondary school.

3 Aims and Objectives
3.1 The proposed aim is to contribute significantly to a reduction in the prevalence of smoking amongst 11-13 year olds, especially girls, in England by November 1994. Fig. 1. A page from the discussion document which preceded the launch of the HEA's National Programme to Reduce Teenage Smoking.