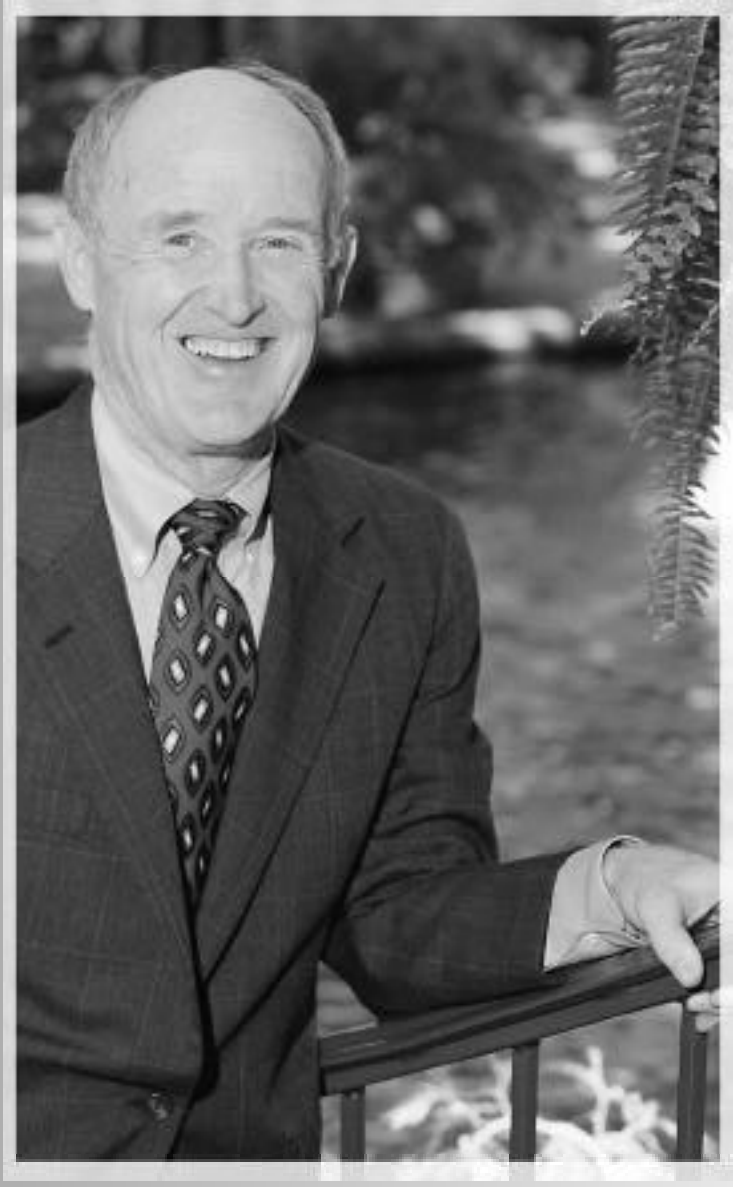
Dee W. Edington

For more than two decades, Dee W. Edington, a researcher, professor, and author, has studied the relationship between healthy lifestyles, vitality, and quality of life. As director of the Health Management Research Center, Edington not only enjoys the constantly emerging challenges of running a dynamic and innovative think tank, but his research, concepts, and materials have formed the basis of health promotion and wellness programs in more than one thousand corporate worksites.



Examining the Past and Future of Health Promotion

Senior Co-Editor George Pfeiffer, M.S.E., AWHP, explores the past and future of the health promotion industry with long-time friend and industry expert Dee W Edington, Ph.D. Edington, who is director of the Health Management Research Center, Division of Kinesiology at the University of Michigan in Ann Arbor Michigan, is a professor and research scientist in the School of Public Health, frequent faculty member of the Michigan Business School's Executive Education Program, and serves as AWHP's Worksite Health's *Research Committee Chair*

George Pfeiffer: You and I go back twenty-five years, and we have seen some significant changes in worksite health promotion. What is your state-of-the-union message regarding worksite health promotion today?

Dee W. Edington: We are entering into an age of enlightenment. Worksite health began as a means to reduce the precursors to disease. However, over the years, the outcome measures changed from psychological hardiness and disease prevention to health-care utilization and costs as well as productivity. To impact the total organization, attention to everyone is needed, not just the segment of the population with single or multiple high risks.

The most effective programs are those that combine high-risk reduction with low-risk maintenance for the right person at the right time. The outstanding programs have three major components: disease management, screening and preventive services, and high-risk and low-risk interventions.

The ability to personalize and deliver interventions through improved data-management systems and personalization will take the field to the next level of success.

Pfeiffer: You and your staff have been recognized as leaders in prospective medicine, namely using health-risk appraisal technology as a predictive tool in assessing individual and group health risks and in cost modeling. How has HRA technology changed over the years and where do you see it going?

Edington: Over the past twenty years, we processed more than two million HRAs. During this time, the algorithms have developed and changed from mortality-related outcomes to morbidity and health-care costs. Our current Wellness Score is a combination of health risks, the interaction of the health risks, and use of preventive services.

The science of group predictions is now well developed; however, the emerging science is refining the outcome predictions for individuals. What is now driving our research is the priority risk that should be reduced or maintained to result in a low-risk or low-cost outcome within the next two years. Two years is critical since many, if not most, organizations and health insurers are interested in outcomes within this time period.

Pfeiffer: Many organizations are reluctant to establish evaluation architecture when designing their health promotion initiatives. A common reason is lack of resources and expertise. In fact, in some cases, comprehensive evaluation programs can cost more than the actual interventions. If an organization doesn't have the required resources for program evaluation, what should it measure if possible?

Edington: Our program-evaluation methods have always been driven from the data-management system, thereby avoiding expensive third-party evaluation. A good-data management system will capture the single most important marker, which is participation.

One-time participation is important, but repeat and multiple program participation is the metric most predictive of good outcome measures. The critical measures of participation are cumulative and multiple, not annual and single.

Pfeiffer: Today we hear a lot about so-called health and productivity management. As a scientist, how would you define productivity within this context? Do you believe that evaluation models can actually measure health promotion as an independent variable in lieu of other confounding factors on productivity?

Edington: Productivity is by far the most complex outcome measure we have attempted to model. Generally, you think of productivity as the sum of all the work accomplished during a unit of time. If the measures of productivity were simple, then we could assume your productivity is zero when absent and 100 percent when present.

In fact, some jobs do follow that pattern. However, new work rules are changing that simplistic approach, and we find that some people are productive while absent from the physical location and others are not as productive while at work for a variety of reasons.

A universal measure of productivity eludes us and is difficult to measure except for specific job classifications. We were fortunate to find one such situation with call-center operators. We were able to develop a worker's productivity index and to demonstrate a relationship with positive health behaviors.

However, this index is specific to call-center operators. As you suggest, the factors influencing productivity are complicated and have escaped behavioral scientists for years. I do not have much hope for a universal measure of individual worker productivity.

Pfeiffer: It appears that as an industry the worksite health promotion community hasn't been very successful in making a strong economic argument about the efficacy of health promotion within an occupational setting. It seems to me that this is more of a marketing problem (to decision makers and legislators) rather than the absence of good data. Do you agree, and if so, what must we do to change this perception?

The best way to avoid elimination is to make worksite health a serious business strategy with measurable business outcomes.

Edington: I agree to some extent, although as a scientist I feel we continue to need additional evaluation data.

However, I agree that we have a marketing problem. When health-care insurers and political leaders discuss health care, the major issues continue to be medical and pharmaceutical expenses. We lack a political presence, which could come about by an overwhelming amount of good data published by several prominent corporations and unions supporting our efforts, or a more active political agenda. Personally I support the former option since we have a more direct influence on the message.

Previously, we did not have the receptive ears of the decision makers. That is changing as corporations, federal and state agencies, pharmaceutical companies, and others are beginning to engage in this effort and call for more prevention. I am more optimistic now than I have been in the past twenty-five years.

Pfeiffer: Having a strong evaluation base with cost-benefit data hasn't been a guarantee that a program will survive, let alone expand. We are aware of some award-winning programs being downsized and even eliminated in spite of their demonstrated cost benefit. Though strong data is going to win many arguments with the corporate comptroller, are we ignoring other organizational dynamics that are just as important in determining if a program is going to be sustained?

Edington: We should feel no discrimination. Good and poor programs as well as good and poor companies are being eliminated for a variety of reasons. The best way to avoid elimination is to make worksite health a serious business strategy with measurable business outcomes. Writing a good business plan and implementing the plan is under our control.

Other organizational dynamics are important, but most of them are beyond our control. For most corporations, it takes a major and consistent effort to influence organizational dynamics and culture. We should use the resources at our disposal to influence organizational dynamics and environmental factors as a low-risk maintenance strategy. However, the true changes in these factors require a much broader approach to organizational dynamics and culture.

Pfeiffer: With the growth of the Internet, there are new opportunities to reach individuals and distinct groups with very targeted, tailored interventions. In fact, it's estimated that there are more than sixteen thousand health sites on the Internet today. Yet, there are some serious concerns by individuals and right-to-privacy groups that the Internet has no safeguards in protecting individual health data. Do you see these concerns as being a significant obstacle to broader participation, and how do you view the expanding role of electronic technology in general?

Edington: The Internet is an important learning tool, but it exposes us to

a serious confidentiality issue, as you suggest. Obviously, we need to defend the right to privacy when it is threatened.

However, this concern should not deter our efforts to use the technology as a new learning tool. We have the technological ability to maintain confidentiality and continue to build our programs on the basis of self-disclosure. Access to the Internet and its appeal to a limited subpopulation are perhaps the major drawbacks of this technology becoming the dominant learning media within the next few years.

Productivity is by far the most complex outcome measure we have attempted to model.

Pfeiffer: After twenty-five years in the field, what do you and your group feel are your most important research findings?

Edington: Perhaps I can speak for the more than two hundred people who have spent time with us at the Health Management Research Center.

Three of our most important findings are (1) changes in health-care costs follow changes in risks in both directions, (2) low-risk maintenance is as important as high-risk reduction for the long-term health of a population, and, (3) managing the right risk in the right person at the right time is critically important to obtain positive outcome measures within a two- to three-year period.

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