Demographics and Diversity of Central and Western US Worksite Health Promotion Professionals: A Pilot Study

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Abstract

English:

Because of the disproportionate amount of health problems and limited access to care in ethnically diverse populations, our national health objectives call for interventions that include recruitment of health promotion professionals from the ethic populations they are to serve.

The purpose of this pilot study was to provide an overview of demographics including the current status of culturally diverse ethnic group representation in worksite health promotion professionals in the Central and Western regions of the United States. Surveys were FAXed to a stratefied random sample of 190 worksite health promotion professionals in 15 states. The instrument consisted of a series of multiple-choice questions to describe respondents' worksite and personal demographics.

The majority of respondents were female, and most possessed at least a Master's degree. As the predominant ethnicity of the respondents was overwhelmingly White, results also provided some evidence of the under-representation of diverse ethnic groups among these regions' worksite health promotion professionals. The information gathered could be used to improve the regions' recruitment and retention of professionals, specifically culturally diverse professionals, into the worksite health promotion field.

Spanish:

Debido a la cantidad desproporcionada de problemas de salud y el acceso limitado al sistema de salud en las poblaciones éétnicamente diversas, nuestros objetivos nacionales de salud indican la necesidad de intervenciones que incluyan el reclutamiento de profesionales en promocióón de la salud de las poblaciones éétnicas que sirven.

El propóósito de este estudio piloto fuéé el proveer una idea general de los aspectos demográáficos incluyendo el estado actual de la representacióón de los grupos éétnicos diversos en profesionales dedicados a la promocióón de la salud ocupacional en las regiones Central y Occidental de los Estados Unidos. Los cuestionaros fueron enviados por Fax a una muestra al azar de 190 profesionales en el áárea de la promocióón de la salud ocupacional en 15 estados. El instrumento consistióó de una serie de preguntas de seleccióón múúltiple para que los participantes describieran sus datos demográáficos personales y el lugar de trabajo.

La mayoríía de los participantes eran mujeres y la mayoríía poseíían al menos un grado de maestríía. El grupo Etnico predominante de las personas que respondieron fuéé el de los Blancos, resultados que proveyeron evidencia de la baja representacióón de los diversos grupos éétnicos en los profesionales de la promocióón de la salud ocupacional. La informacióón recolectada puede ser usada para mejorar el reclutamiento y retencióón de profesionales, especííficamente profesionales de grupos éétnicos variados en el campo de la promocióón de la salud ocupacional.

Key words*: worksite health promotion, diversity in the workplace, minority groups, student recruitment – education, education - graduate*

Introduction

Although our national health promotion objectives for the year 2010 target many of the leading causes of morbidity and mortality among racial and ethnic minority groups (UDDHHS, 2000), this emerging majority still experiences a higher rate of disability and death due to both chronic and communicable disease than the White population (Ramirez, 1995). Because of the disproportionate amount of health problems and limited access to care in these high-risk, ethnically diverse populations, our national health objectives also call for interventions that include recruitment of health promotion professionals from the ethic populations they are to serve (USDHHS, 2000).

As the face of America changes, so too, does the face of the American worker. For example, workers in

the Hispanic population, projected to be the largest minority group in the county in the next five years, are entering the labor force at an ever-increasing rate (Joinson, 2000). The worksite, therefore, provides an opportunity to offer health promotion and disease prevention programs to a growing number of ethnic groups with a wide variety of health risks (Aguirre-Molina & Molina, 1990). Although ethnically diverse groups represent about one-quarter of the American population, they make up only about ten percent of health, allied health, and associated health professionals (USDHHS, 2000). For the worksite health promotion field to meet our national health objectives, creation of culturally appropriate programming as well as recruitment of ethnically diverse professionals to deliver the programming is essential.

The purpose of this pilot study was to provide an overview of demographics including the current status of culturally diverse ethnic group representation in worksite health promotion professionals in the Central and Western regions of the United States. Worksite health promotion professionals are dedicated to enhancing the personal and organizational health of employees and their families (Association for Worksite Health Promotion, 2001). This research was conducted in order to gather information to more accurately describe demographic characteristics of Central and Western US worksite health promotion professionals including predominant ethnicity. The information could be used to improve these regions' recruitment and retention of professionals, specifically culturally diverse professionals, into the worksite health promotion field.

Methods

Sample:

After institutional review board approval, surveys were FAXed to a stratified random sample of 190 Association for Worksite Health Promotion (AWHP) professional members in 15 central and western states (Colorado, Iowa, Kansas, Missouri, Nebraska, North Dakota, South Dakota, Wyoming, Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, Wisconsin) during January and February, 2000. Because of grant funding parameters, the focus of the study was on the central region of the United States; therefore, the sample is not representative of east and west coast regions.

The list of health promotion professionals was developed from the 1999-2000 AWHP Membership Directory- Professional Members. The total number of AWHP members at the time was 1237 professionals, as 36.2% (448/1237) of the membership was from the central and western regions. Although these members may not truly reflect the practicing profession of worksite health; they identified themselves, through association membership, as involved in advancing the field of worksite health promotion throughout the world (Association for Worksite Health Promotion, 2001).

Worksite health promotion professionals were pre-contacted by telephone in December 1999 to verify their FAX numbers and to alert them that the survey will be sent in January. Because of business' easy access to the FAX machine, the perception of urgency and importance in a FAX transmission, the cost-effectiveness of the strategy, as well as the speed of survey return, the FAX survey method has been shown to be a useful technique for surveying business and professional groups (Esselmont & Pickering, 1991; Shannon & Arbet, 1994).

The first round of surveys garnered 108 FAX responses. Financial constraints limited the number of follow-ups to non-respondents. It was assumed that since the sample was pre-notified and the surveys were personalized that a respectable response rate would be achieved with only two rounds of surveys. A second round was then FAXed to non-respondents and gained 32 more FAX responses for a total of 140, a response rate of 74%.

Instrument:

The survey was pre-tested with a group of 12 worksite health promotion, exercise physiology, and wellness professionals and then revised. Minimal changes in wording were made as the survey only asked questions about demographics that were not listed in the professional directory. The instrument consisted of a series of multiple-choice questions to describe respondents' worksite category and size strata and to identify their gender, age, job classification (entry-level/assistant health promotion director/health promotion director), years of employment in the field, highest academic degree achieved, predominant ethnicity, and income range.

The categories to self-report ethnicity were selected according to Federal Register Part II: Revisions to the CDC Standards for Classification of Federal Data on Race/Ethnicity (Federal Register, Part II, 1997). The minimum categories for race were: American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. The minimum categories for ethnicity were Hispanic/Latino and Not Hispanic Latino. The new standards (allowing respondents to select one or more races and to include a Some Other Race category), to be implemented by January 2003 by all federal agencies, were not used in this study (US Census Bureau, Population Division, 2000).

Analysis:

Worksite and respondents' personal demographics were tabulated for frequency and proportion. Chi-square analysis was used, however, due to the small expected cell frequencies in some contingency tables, variables were recoded and frequencies within categories were collapsed.

Results

As seen in the table, the predominant ethnicity of the respondents was overwhelmingly White (136/140, 97.1%). Most respondents were employed in either a corporate-based (51/140, 36.4%) or hospital/clinic/managed care setting (43/140, 30.7%). Extra-large organizations (77/140, 55%) and large organizations (31/140, 22.1%) employed just over three-fourths of the respondents. Females were significantly ($df=1, X^2=7.778, p<.005$) more likely than males to be employed by a company or organization of more than 250 workers.

The majority of respondents were female (105/140, 75%), between 31-40 years of age (72/140, 51.4%), and most (68/139, 48.9%) described their job classification as 'Other' (e.g. Community health educator, consultant, CEO/owner/partner), followed by Health Promotion Director (63/139, 45.3%). In addition, over half (84/140, 60%) had received their Master's degree.

Table 1. Demographics of Central and Western Region Worksite Health Promotion Professionals

	Freq (N=140)	%
Company/Organization		
Corporate-based	51	36.4
Hosp/Clinic/Mged Care	43	30.7
Educ/Govt	13	09.3
HP Product/Serv Vendor	25	17.9
Other	08	05.7
Company/Organization Size Strata		
Less than 50 employees	17	12.1
50-99 employees	02	01.4
100-249 employees	13	09.3
250-749 employees	31	22.1
750+ employees	77	55.0
Gender		
Female	105	75.0
Male	35	25.0
Age		
20-30 years	24	17.1
31-40 years	72	51.4
41-50 years	37	26.4
51+ years	07	05.0
Job Classification		
Entry Level Specialist	03	02.1
Assistant HP Director	05	03.6
HP Director	63	45.0
Other	68	48.6
Missing	01	00.7
Total Years of Employment in the HP Profession		
Less than 5 years	16	11.4
5-10 years	58	41.4
11-20 years	52	37.1
21+ years	12	08.6
Highest Degree Achieved		
HS Diploma	01	00.7
BS Degree	49	35.0
MS Degree	84	60.0
Doctoral Degree	06	04.3
Predominant Ethnicity		
White	136	97.1
Black/African-American	02	01.4
Hispanic or Latino	01	00.7
Average, Yearly Income		
Less than 20K	03	02.1
20-30K	13	09.3
31-40K	32	22.9
41-50K	35	25.0
More than 50K	47	33.6
Missing	10	07.1

Most respondents were employed in the worksite health promotion profession for five to 10 years (58/138, 42.0%), followed by 11-20 years in the field (52/138, 37.7%). Respondents over 40 years of age were significantly (df=1, X^2=18.035, p<.001) more likely than younger respondents to be employed in the field for over 10 years.

Of those reporting their income, many (47/130, 36.2%) averaged over $50,000 per year. Respondents over 40 years of age were significantly (df=1, X^2=12.775, p<.000) more likely to make over $40,000 per year as were those with 11 or more years of employment in the field (df=1, X^2=14.386, p<.000) and those possessing a Master's degree or above (X^2=11.741, df=1, p<.001).

Discussion

This pilot study provided an overview of demographics including the current status of culturally diverse ethnic group representation of worksite health promotion professionals in the Central and Western regions of the United States. The information gathered could be used to improve these regions' recruitment and retention of professionals, specifically culturally diverse professionals, into the worksite health promotion field.

In general, the majority of respondents were female, in their 30's, and most possessed at least a Master's degree. The relative youth and educational level of the respondents was surprising. This may be possibly due to worksite health promotion being viewed as an emerging profession, and that the most significant source of training recommended is the Master's degree (Bureau of Labor Statistics, 2002).

Since the study was limited to just AWHP professional members, limited to just 15 states, and the sample size was not conducive to an inferential statistical analysis, a larger sample size in future studies is needed to more accurately assess the relationship between predominant ethnicity and the other demographic variables. However, as the predominant ethnicity of the respondents was overwhelmingly White, results also provided some evidence of the under-representation of diverse ethnic groups among these regions' worksite health promotion professionals.

To address similar concerns in their fields, other health professions have identified and recommended strategies that can possibly be implemented to meet this region's lack of diversity in its worksite health promotion practitioners. The epidemiology field has recommended that its college degree programs adopt comprehensive written plans for recruitment of underrepresented students (St George, et. al, 1997), and physician assistant program directors have demonstrated that commitment to minority retention through pre-matriculation programs and academic support activities were successful strategies (Bowlin & Gugelchuck, 2000). In the field of medicine, there has been no increase in the numbers of minorities entering medical school since the mid 1970's. Therefore, medical schools are now encouraged to appoint an administrator to be responsible for minority affairs (AAMC, 1999).

Studies also indicate that ethnically diverse groups are not represented in high numbers in the place where the worksite health promotion field draws much of its professional membership - United States' university health education programs (Crabtree, Wagner, &Antrim, 1989). In addition, from the early 1980s to the early 1990s, only about 8% of all health education doctorates went to ethnically diverse students, with no trend toward a future increase in numbers (Crase & Hamrick, 1996). Ethnically diverse students comprise only a small number of the doctoral student population in health education, the place where potential worksite health promotion faculty members are drawn (Crabtree, Wagner, &Antrim, 1989). The medical and research doctoral pipeline also has a minority recruitment problem. Pipeline initiatives recommend that science and health care career preparation now begin in elementary school, not high school (Wilson & Balotin, 1999).

If the results obtained in this pilot study are confirmed in more extensive and definitive studies, then the leaders in the worksite health promotion field should design intervention programs for both the academic and professional settings. Additional attention needs to be given to providing assistance to those of diverse ethnic groups to pursue health promotion degrees, encourage mentoring of faculty members from diverse ethnic groups, promoting early /pre-graduation recruitment, increasing the number of ethnically diverse faculty and administration, and recruiting and retaining ethnically diverse worksite health promotion professionals (USDHHS, 2000).

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