Strategies to Strengthen the Health Promotion Workforce in the PHO Environment

Discussion Paper prepared for the Ministry of Health, based on consultation at the National Networking Hui for Health Promotion in PHOs, June 2006

Background

The formation of Primary Health Organisations (PHOs)

Primary Health Organisations (PHOs) have been formed to be the vehicles for the implementation for the New Zealand Primary Health Care Strategy. They are charged with working to decrease health inequalities between groups and improve health outcomes of the population, by using approaches to improve, maintain and restore the health of the population[1]. Health promotion is seen to be a key component of the population health approaches to be used by PHOs to achieve these goals, an important complement to personal health care approaches [2]. The general population is invited to enrol in a PHO via their nominated general practice, and the PHO is responsible for providing a minimum set of coordinated primary health care services for that enrolled population. Capitated funding is paid to the PHO to subsidise first point of contact care on the basis of the demographics of their enrolled population, with this funding being weighted for ethnicity and socio-economic deprivation. In addition PHOs receive Services to Improve Access funding to provide new services or enhance existing services to reduce barriers to access for Māori, Pacific and populations from residential areas designated as Quintile 5 (the most socio-economically deprived areas), and funding for health promotion services. The health promotion funding is calculated at $1.90 per enrolled person, with a slight weighting to $2.29 for those enrolled who are Māori, Pacific or live in Quintile 5 areas, increasing to $2.67 for those who are Māori or Pacific *and* live in a Quintile 5 area.

Variety in size and structure of PHOs

The first PHOs were formed in 2002 in the upper North Island, and the move to PHOs essentially spread southwards, so that by June 2006 there were 81 PHOs spanning the country, some having been in existence nearly four years while others have been operating less than one year. The size and structure of PHOs varies considerably, and this diversity impacts on their operationalisation of the health promotion funding stream.

The smallest PHOs have enrolled populations of just over 5000 while the largest serve enrolled populations of over 300,000. This variation in size of the enrolled population has major implications for the PHO health promotion budget. PHOs also vary in their origins. Some are ethnic specific, focused on Maori or Pacific populations, and for Maori led PHOs, may be linked to a particular iwi. Some PHOs are geographically based, encompassing all the general practice providers in an area, while others are based on collections of general practice teams who previously operated as an Independent Practitioner Association (IPA) or as a 'third sector' community trust. In some regions this results in several PHOs serving the same geographic population, producing challenging notions of who the 'community' served by the PHO actually is. While the Ministry of Health 'Minimum Expectations of PHOs' requires that PHOs are responsive to their communities, PHOs vary in the extent and formalisation of their relationships with these communities. PHOs also vary in the extent and formalisation of their relationships with NGO providers – in some instances there are NGO representatives on the PHO Board or other key groups who influence decision-making in the PHO, and/or NGO staff may have dual employment, working part-time for the PHO. There is also diversity in the arrangements PHOs have to gain management support. In some instances all management services are provided 'in house' by staff directly employed by the PHO who have a locality office in the geographic region served by the PHO. In other cases, management support may be obtained from an organisation geographically sited in another part of the country, so the management is 'virtual', with no or minimal local presence in the community being served.

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[1] Ministry of Health, N.Z., *New Zealand Primary Health Care Strategy*. 2001, Ministry of Health: Wellington.
[2] Ministry of Health presentation at the National Networking Hui for Health Promotion in PHOs, June 2006

Variety in arrangements for provision of health promotion services in PHOs
All of these factors contribute significantly to the diversity in arrangements PHOs have for their contractual provision of health promotion services. For smaller PHOs the total health promotion budget may be less than $20,000, which may be used to fund a part-time health promoter, or to provide some programmes in the community that are planned and managed by a projects manager who has minimal health promotion background. This is in contrast to some of the larger PHOs who have a 'health promotion team' with considerable health promotion expertise. Some PHOs of a variety of sizes have chosen to fully contract out their health promotion funding to other NGO health promotion providers.

Variety in the support available for health promotion development in PHOs
There has been limited guidance from the Ministry of Health regarding their expectations of the health promotion funding stream in PHOs. Annual funding of $50,000 has been offered to DHBs to provide support for the development of health promotion in PHOs but DHBs have varied in their arrangements for delivering this support[3]. In some instances the local regional Public Health Unit (PHU) has been contracted to provide this service, facilitating close links between PHU and PHO staff; in other areas the DHB has delivered the support, with minimal involvement of the PHU; and in other areas there has been no formal external support for PHO health promotion development. In addition, there is considerable diversity in the health promotion expertise of DHB staff who have responsibility for the annual approval of PHO health promotion plans and the on-going monitoring of the performance of the PHO in respect of these plans. Subsequently there are significant inconsistencies between what is considered an acceptable use of PHO health promotion funds in different parts of the country. This challenges the creation of an environment that encourages the formation of a 'learning community' for those involved with health promotion in PHOs.

The gathering of input into this document

It is in this setting that those involved with health promotion in PHOs were invited to gather in Wellington in June 2006 to network and share their experiences of the PHO journey, having not had such an opportunity since the Primary Focus Conference in March 2005. Forty-three of the country's 81 PHOs were represented at the hui. While those present came from the range of PHOs described above, smaller PHOs predominated in those not represented. There were also some staff present from DHBs, PHUs and the Ministry of Health who work in a variety of roles related to health promotion in PHOs.

During the hui, those present heard from the Ministry of Health that the PHO health promotion funding stream is intended to have a significant focus on the reorientation of health services, as per the fifth stream of the Ottawa Charter. This is seen to necessitate a much closer relationship between health promotion and treatment services than is usually the case. For many at the hui, this was the first time they had heard this vision articulated, and this sat in tension with their commitment to community development approaches, given their limited resource.

The hui provided an opportunity to promote subsequent small group discussion about strategies to strengthen the Health Promotion Workforce in the PHO environment. This paper reports on those discussions, and is grouped under the eight questions specifically put to the groups. Although there was not an opportunity for the participants to further discuss all of these specific recommendations as a large group, many of the recommendations had been made in other contexts during the hui, and all participants have had an opportunity to review this paper and make suggestions for modification.

It is likely that many of the suggestions will be very similar to those made by people in other parts of the health promotion workforce, but with the continual need to recognise the interrelationship with the unique setting of primary care and PHOs as outlined above.

[3] This funding will cease as of July 2006

1. How can strong and diverse leadership in health promotion be developed and promoted?

Those working in health promotion in PHOs need to be leaders, whether that is leading a team of health promoters in the PHO, leading a process in the community, or working with clinical staff to lead the change in focus required by the Primary Health Care Strategy. This leadership is seen to need the support of colleagues working in similar situations, through facilitated forums and face-to-face and electronic opportunities to share learnings. A peer mentoring programme that was formalised nationally would enhance these opportunities for reflective practice. There is also seen to be a need for formalised professional supervision, to be used in much the same manner as the clinical supervision promoted for clinical colleagues. Currently there are limited opportunities for this collegial support to nurture leadership. However going forward there is seen to be a need for much greater support from the Ministry of Health and DHBs collectively, to

(a) mandate the time required for these activities so that it is formally and consistently recognised in contracts
(b) provide the funding and organisational support necessary.

Formal leadership training opportunities such as the DHBNZ LAMP programme would be welcomed, although these would potentially need to be modified to ensure relevance to the setting of PHO health promotion. One of the advantages of such training is seen to be the networks created. In addition culturally specific leadership training for both Māori and Pacific health promoters would complement generic training. Recognised leaders also require media training, preferably before they are faced with challenging media situations.

Providing health promotion training opportunities for the health promotion workforce at all levels is also seen to nurture leadership by giving greater credibility to health promoters. This is especially needed when working in a clinical setting where there is frequently a higher expectation of professional qualifications than there might be in other health promotion settings. In addition to qualifications, increased training opportunities should improve the quality of health promotion work being offered in PHOs, which will also enhance credibility and greater potential for leadership opportunities.

In addition training about health promotion 'ways of working' for those in management and on Boards of PHOs is seen to have the potential to support the growth of health promotion leadership by validating health promotion as an important component of PHO services to achieve the vision of the primary care strategy. The strategic use of Public Health Medicine and Primary Care specialists may help to validate this perspective.

The encouragement to document and publish health promotion work in PHOs is seen to be important to nurture leadership.

Community leadership is also seen to need to be given a stronger voice, and strengthened alongside the leadership of health promoters.

2. How can a strong focus on community development for the health promotion workforce be maintained?

Community involvement in PHO processes is a minimum requirement of PHOs according to Ministry of Health documentation, and some would suggest community should be at the CENTRE of all PHO work. There is a challenge in defining the 'community' for community development approaches, given the variety of PHO structures referred to previously; however even given this tension, the commitment to this community role varies across the PHOs, and health promotion workers in PHOs have an important role in enabling the community voice to be heard. The Board/management training recommended above could also help to improve understanding of, and raise the profile of, community development strategies, especially if it makes use of practical examples. This Board level training would also need to emphasise the long-term nature of community development work, and therefore the need for long term funding commitment.

However it is also seen to be important not to overload 'the community', but to support the PHO to partner with existing structures and key agencies/initiatives that are interested in determinants and promoting community development models (e.g. some of the HEHA and Cancer control initiatives, local Authorities). Providing training for people from the local community in health promotion, so that health professionals can work alongside people from the community who are already trusted is key.

Gathering the evidence in support of community development models and equipping health promoters with that evidence is also seen to be important to support the use of these models in the setting of PHOs.

3. How can a strong focus on the determinants of health and the reduction of inequalities for the health promotion workforce be developed?

The focus on determinants and reducing inequalities is seen to need strategic leadership by the Ministry of Health and DHBs, to model best practice. Intersectoral work driven nationally – Ministry of Health, Ministry of Education, Ministry of Social Development working together - would contribute to a culture more supportive of regional and local work to address determinants. Existing tools such as Treaty Understanding of Hauora Aotearoa-New Zealand (TUHA-NZ), Health Equity Assessment Tool (HEAT), and Health Impact Assessment (HIA) need to be promoted more widely, with practical demonstration of their use. Reconsideration of national priorities (e.g. nutrition and physical activity versus healthy housing, improving literacy) also needs to be entertained, along with continued emphasis on routine collection of quality ethnicity data in a variety of health and non-health settings (e.g. including WINZ).

There is a need for the evidence about what does actually work to reduce inequalities to be gathered centrally and be readily available to those working on the ground in PHOs. This would enable the health promotion workforce to provide a stronger influence for the inequalities focus in the wider planning processes of the PHO (e.g. the use of Services to Improve Access funding). This need for a close relationship between SIA and health promotion planning is yet to be explored to any major degree in most PHOs. In addition ongoing evaluation and dissemination of results is vital to prevent people reinventing the wheel, both for success and potentially for failure. Given the small size of many PHO health promotion and SIA budgets, some of this evaluation would need to be funded centrally.

Targeting health promotion resource to those with the greatest health inequalities and then managing expectations is also seen to be critical. This would potentially entail a review of the current funding mechanism for PHO health promotion, needing considerably more weighting for high needs populations. Several from the hui are committed to progressing this discussion nationally.

4. How can the voice of health promotion within public health and primary health care be strengthened?

Many of the suggestions for this question are covered in answers to previous and subsequent questions:

- a facilitated national network for health promoters in PHOs, both electronic and face-to-face
- a trained workforce who promote high standards of health promotion practice and also clearly understand the setting of primary care and PHOs, including the detailed workings of their own PHO.
- good research and evaluation to provide a strong rationale for planning.

In addition there is also still a need to promote the use of common terminology (e.g. the distinguishing of health education and broader health promotion approaches), and the need to celebrate and showcase success stories and support clinical staff who are champions for health promotion. Encouraging the secondment of public health medicine registrars to PHOs to work closely with health promotion staff as well as PHO management (e.g. assisting with needs analysis, PHO policy development, SIA planning) also has potential to strengthen and validate the health promotion voice in primary care. This may also strengthen the support these registrars give to health promotion in their subsequent careers in public health.

There is also a need for national level discussion about health promotion indicators for the PHO performance management programme[4], and to contribute to ongoing DHB/PHO health promotion planning processes. Currently consideration of the strategic use of PHO health promotion funding may be given limited priority by PHO Boards and managers because the amount of health promotion funding is small relative to personal health funding in PHOs. However those working in management and governance in PHOs and DHBs need practical tools and support to demonstrate how health promotion integrates with other primary care activities, rather than high-level theoretical discussions. In the planning for devolution of the PHO health promotion funding to DHBs, the Public Health Directorate could work with DHBNZ to provide workshops for DHB and PHO management to equip them to have appropriate expectations for health promotion planning and implementation in PHOs and its integration with other PHO activities. Useful indicators would be an important tool for such workshops.

Utilisation of the media, and social marketing to 'sell it [health promotion] rather than tell it' was seen to be potentially important avenue to strengthen the voice of health promotion, as yet relatively unexplored.

Well thought through submissions on public health issues of significance will also validate the voice of health promotion.

5. How can access, cohesion and linkages in the development and delivery of health promotion training best be achieved?

A two-tiered process is seen to be important in developing cohesion and improving access to training for health promotion in the PHO setting:

(a) for the health promotion workforce, a system of stair-cased training options that provide recognised and nationally endorsed career pathways is key. It is important this

- utilises and builds on training options that have already been developed
- is delivered regionally where possible to improve access
- has associated scholarships/funding available to enable staff from smaller PHOs to participate
- and is NZQA accredited

(b) nationally consistent education about health promotion for PHO Boards, management and clinicians. This could include courses for specific segments of the primary care sector (e.g. nurses), and build on and give cohesion to the significant work already commenced by health promoters working in PHOs in various parts of the country.

With a well trained workforce, the potential for health promoters themselves to be able to provide high quality community training, adapted to local circumstances, will then be much increased.

An organised network for health promoters in PHOs as noted previously would also provide opportunities to increase cohesion by the sharing of learnings, with associated peer review. Both the face-to-face aspects and the internet forums suggested would be important for these processes.

6. How can competence in the workforce for health promotion be built and ensured?

The competencies previously developed by the Health Promotion Forum would be a good starting point that could be modified for the primary care sector, with contractual requirements for all those employed to positions designated as health promoters to have basic competencies or be working towards acquiring these. Similarly contractual requirements to maintain competencies would help to ensure ongoing competency. Competency based practising certificates would be a controversial but potential mechanism to

[4] Current 'population health' performance programme indicators (eg. Cervical screening, mammography, smoking rates) are focussed on disease prevention rather than health promotion

ensure ongoing competence; implementation would require a substantial investment in workforce development in addition to the robust processes necessary for the system to be equitable and responsive.

While clear that formal qualifications and skill building are essential going forward, those at the hui were also mindful of the need to recognise community experience and cultural competencies that are vital to effective community development approaches and suggest further work needs to be done in this area.

7. How can cultural competence in the workforce for health promotion be built and ensured?

Consideration of cultural competence needs to be part of every health promotion programme planned, and appropriate training built into the plan. Treaty of Waitangi approaches need to be practical and sustained. Employment of culturally specific staff to work with target populations (e.g. Māori for Māori, Pacific for Pacific) is ideal. The expertise of these people, along with community leaders, can then be drawn on within the PHO to improve cultural competence; this will facilitate wider cultural competence but also ensure that local community needs are met.

Mentoring and reflective practice are also important to ensure cultural competencies are developed and maintained. Train the trainer programmes for cultural competency would help to ensure sustainability.

8. Are there any other strategies you would recommend to support the development of a well trained workforce for health promotion?

Integration of international learning about workforce development for health promotion, with careful attention to adaptation for the unique features of the setting in Aotearoa New Zealand, is seen to be important. It is currently unclear to what degree this is being undertaken. Alongside this, encouragement of New Zealand health promoters to publish and present internationally would potentially require increased logistic support, but has potential to improve the credibility of health promotion as a strategic influence in primary care in Aotearoa New Zealand.

Further work to better understand the potential integration of health promotion and general practice delivery models needs to be lead nationally, and then disseminated appropriately to those actually working in PHOs and all those in the health promotion sector who interface with PHOs in their work (e.g. PHUs, NGOs). Continued work to clarify terminology, and expectations of what the work of a health promoter actually is in the setting of PHOs will be important in determining the training needed.

All work to better define the role and skills of health promotion needs to be balanced with inclusive language that embraces the broad range of life experiences that currently enrich the health promotion workforce.

Enhancement of Ministry and DHB processes to promote a learning culture is also key to supporting workforce development. At present PHOs, among others, are putting large amounts of time into developing proposals to apply for additional funding streams to contribute to their population health approaches. A learning culture would feed back to them useful information about their proposals, whether they are successful or not - the good features of their proposal, the gaps, what would have enhanced it.

The importance of not reinventing the wheel was emphasised. There is potential to strengthen national organisations supporting health promotion (e.g. Health Promotion Forum, Public Health Association) and encourage them to have special interest groups for health promoters working in PHOs.

A pay scale in keeping with the stair-cased training pathway, consistently applied, would help to motivate people to undertake training, but again will also need to recognise important community and cultural experience that are key to successful health promotion particularly in high needs communities.

The departing message was clear: the health promotion in PHO workforce see the need for a nationally consistent, supported career pathway as critical, along with opportunities to enhance reflective, inequalities-focused leadership in their work at the interface of primary care and public health. They look forward to working with the Ministry of Health to make this a reality.