

Strengthening health promotion in community health: the views of health promotion practitioners

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Abstract

Issue addressed

Health Promotion is a key role of Victorian Community Health Services but a 2007 report by the Victorian Auditor General found that organisations experience a range of challenges in integrating health promotion with their service delivery roles. A survey of health promotion workers in community health sought to document their perceptions of the strengths and weaknesses of health promotion in their organisations, the barriers to more effective practice and the changes required to strengthen practice across the sector.

Methods

An online survey was disseminated via email to health promotion workers in community health services across the state.

Results

A total of sixty-one responses were received from a broad cross-section of organisations and locations. The strongest theme to emerge was that inadequate resources are the major barrier to effectiveness. Other barriers include a lack of understanding, knowledge and skills in health promotion amongst other health professionals and management, and health promotion having a lower priority than direct service provision.

Conclusions

The responses indicate a strong sense amongst health promotion workers that better outcomes require greater investment in this area of community health practice. For that investment to achieve sustainable results capacity building amongst the community health workforce and management is also critical.

So what?

The views of workers in health promotion roles provide a useful starting point for thinking about how health promotion in community health can be strengthened.

Introduction

One hundred Community Health Services operate across Victoria, delivering a range of primary health care services from approximately 400 sites. These organisations are key players in the delivery of health promotion in Victoria. The Victorian Department of Human Services (DHS) annually invests approximately \$30 million in health promotion in community health services through the Community Health Program.¹ This funding amounts to 7.5% of the estimated combined annual budgets of Community Health Services. Further funding for health promotion activities is provided through other DHS funding streams, other Victorian government departments, the Victorian Health Promotion Foundation (VicHealth), the federal government, local governments, and other bodies such as philanthropic trusts.

Since 2000 Victoria Community Health Services have been operating within a framework known as Integrated Health Promotion (IHP). IHP "refers to agencies in a catchment working in a collaborative manner using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues".² Since the introduction of the IHP framework there has been a focus on capacity building for the health promotion function in community health and in that time health promotion in the sector is seen to have "matured" to the extent that DHS has expressed its "confidence in the sector's ability to do this [the planning and delivery of IHP] well".³

However, a recent investigation by the Victorian Auditor General Victoria into health promotion directed towards promoting healthy eating and physical activity found community health services experience a range of challenges in integrating health promotion with their service delivery roles.⁴ These challenges include difficulties associated with enabling a range of health professionals to incorporate health promotion into their work practices, allocating the health promotion budget across a diverse range of areas, and measuring the impact of health promotion on health outcomes.

DHS has moved to address some of the concerns expressed by the Auditor General by tendering for the development of improved health promotion performance measures for Primary Health funded agencies.³ The rationale given for this was both to improve

accountability for health promotion funds and to strengthen the evidence base for IHP in order to strengthen practice.

A survey of people working in health promotion roles in community health sought to document their perceptions of the strengths and weaknesses of health promotion in the sector, the barriers to more effective practice and the changes required to strengthen the work of the sector.

Methods

An online survey was developed and disseminated to health promotion workers via email. The survey contained a mixture of multiple choice and open-ended questions. A profile of the respondents was collected through questions on their role, the organisation they work for (type of community health service and geographic location), their years of experience in health promotion and in community health and their highest level of education or training in health promotion. The second part of the questionnaire asked respondents to rate their organisation's performance in various areas of health promotion practice as outlined in the Ottawa Charter for Health Promotion⁵ and the DHS Integrated Health Promotion framework.²

The open-ended questions asked respondents to outline their perceptions of:

- Barriers to better health promotion practice in their organisations;
- Effective capacity building strategies for health promotion;
- Strengths of health promotion in community health;
- Weaknesses of health promotion in community health;
- Opportunities for the future development of health promotion in community health;
- Threats to the future effectiveness of health promotion in community health;
- Suggested changes to strengthen health promotion across the community health sector.

During the design of the questionnaire input was received from members of the Northern Metropolitan (Melbourne) Region Community Health Centres Health Promotion Network, Priscilla Robinson, Senior Lecturer in the School of Public Health at La Trobe University, and Vera Boston, Chief Executive Officer at North Yarra Community Health.

Once the content had been finalised the on-line survey was created using Survey Monkey. The questionnaire was pilot tested on members of the Northern Region Community Health Centres Health Promotion Network. The six pilot-test responses were not included in the survey results and colleagues who had completed the pilot version were encouraged to also complete the final version.

The target for the survey was defined as workers in community health services for whom health promotion constitutes the primary focus of their position. The survey was disseminated to this target group in July 2008 by emails passed on through DHS Regional Health Promotion Officers, Community Health Service Chief Executive Officers or senior managers, and Primary Care Partnership Integrated Health Promotion Officers.

Results

Responses Received

Sixty-one responses were received in total, although not all respondents answered every question. As the survey was disseminated via email through third parties it was not possible to determine a response rate amongst those who received the survey.

Responses were received from 29 people working for independent community managed Community Health Services and 32 from integrated or multipurpose Community Health Services auspiced by rural or metropolitan health services. 24 respondents worked for services in a DHS rural region and 37 for services in a DHS metropolitan region. 6 respondents identified their role as Health Promotion Manager, 7 as Manager with responsibility for health promotion, 12 as Health Promotion Coordinator and 28 as Health Promotion Officer. 8 people had a role that fell outside these categories. 41 respondents (67%) had a formal qualification in health promotion.

Areas of concern

There was significant overlap between the responses to different questions on the survey with some key issues recurring in responses to several questions. Amongst these were a number of issues that can be broadly classified as areas of concern for health promotion practitioners.

The strongest theme to emerge was concern over the impact of insufficient resources on the effectiveness of health promotion in community health. This theme was prominent across responses to the questions on barriers to better practice, weaknesses of current practice, threats to future effectiveness and changes people would like to see. Inadequate funding was the most frequently mentioned resource issue, but lack of time and lack of staff also featured strongly in responses. Lack of resources was identified as impacting on the effectiveness of the work people were able to do and the extent to which work is done thoroughly, as well as contributing to practitioners feeling over-stretched.

Concern over the level of knowledge, skills and understanding of health promotion amongst managers and other health professionals in community health was another significant theme. Some respondents described misconceptions that staff had about the role of health promotion, such as that "health promotion is about marketing, handing out leaflets and promoting their programs". Other respondents referred to a lack of knowledge or lack of skills amongst colleagues and managers, both in general terms and with reference to specific areas of health promotion practice, particularly evaluation. Several respondents wrote comments expressing frustration at the "assumption that anyone can just 'do' health promotion" without appropriate training. However, there was recognition from some respondents of the benefits gained from the diverse skill base from which community health can draw.

The commitment of colleagues and management to health promotion was also raised as a concern. Colleagues were seen as not valuing health promotion. Some of the phrases included "culture of indifference to HP" and "relative unwillingness of direct service staff to incorporate HP into their job". Other responses framed barriers around "competing priorities" rather than personal attitudes. Several respondents observed that direct care was given a higher priority by senior management in their organisations. A number of people raised an increasing focus on chronic disease management as a trend that threatens to further undermine commitment to health promotion. Chronic disease management was seen as bringing with it a focus on "downstream approaches" or "secondary prevention" as distinct from health promotion directed at the "determinants" of health. It should be noted that several respondents mentioned the commitment to

health promotion in their organisations, including comments about being “accepted as part of the organisation” and “being recognised as a significant component”.

In policy terms the call for more resources was clearly the strongest theme. More generally the issue of the commitment to health promotion from governments was a strong theme, with several people expressing concern that the Victorian Government is now more interested in chronic disease management than health promotion. In contrast a number of respondents were optimistic that there was increasing support for primary prevention at both federal and state level.

Several people raised workforce issues specific to health promotion practitioners. The recruitment and retention of health promotion practitioners was identified as a challenge. Several issues were seen as impacting on this including a lack of career paths for health promotion practitioners in community health, burn-out and lack of professional recognition, such as a dedicated award. The specific challenges for recruitment and retention for rural health services were highlighted by a couple of respondents.

In terms of areas of health promotion practice, the area which came up most frequently as a concern was evaluation. This was often linked to a lack of time to put into this area, although lack of expertise and skills were also mentioned. The responses to the multiple choice questions told the same story, with impact and outcome evaluation the stages of practice that people rated their organisation’s performance the lowest in. Planning was another area of practice that was mentioned as a weakness.

Areas of strength

Two areas emerged strongly as strengths of health promotion in community health. The close connection that community health has to its local community was the major strength. A significant number of respondents listed community involvement in decision making, “community ownership”, the scope that community health has to work with communities “in partnership” or the ability to communicate directly with local communities as strengths. Another sub-theme was the idea that community health is strong on “community capacity building”, “empowerment” and “community

development". A lot of responses stressed the theme of local focus, being "on the ground" or at the "grass roots level".

The second major area of strength was in building and sustaining partnerships. A large number of people listed partnerships as a strength, with phrases such as "great partnerships" and "partnership building". Particular mention was given to local partnerships and inter-sectoral partnerships. Several respondents talked about the leadership role that Community Health agencies play in partnerships. In the multiple choice questions partnerships was the domain or organisational capacity with the best scores, with 53 out of 57 (93.0%) of respondents rating it as "good" or "very good".

Ways to strengthen

A central aim of the questionnaire was to document the views of health promotion workers on how the practice of health promotion in community health can be strengthened. A number of potential routes to addressing the areas of concern outlined above emerged from the responses. More funding was the most popular call. As well as more funding there were also calls for funding to be delivered on a long-term basis rather than towards short-term projects.

Training and workforce development were the strongest themes in the responses to the question of capacity building strategies that respondents had found to be successful in their organisations. Most of these responses were quite general, referring broadly to training, workforce development or professional development. Some respondents specifically mentioned the Department of Human Services' five-day Health Promotion Short Course.

Issues around the way health promotion is structured within organisations were raised by a number of people but there were diverging views on this. Some respondents suggested there were too many people doing health promotion within their organisations, resulting in resources being thinly spread, whilst others wrote that too few people were engaged in the process. Several people mentioned the creation of dedicated health promotion teams as an effective capacity building strategy employed in their organisations. A few respondents called for more leadership from DHS on how health promotion should be structured in organisations.

Gaining management support was another strong theme on capacity building. Some of the strategies that were referred to in relation to this included training for managers, having a Health Promotion Manager on the senior management team, and working to establish relationships with senior management and boards.

Strategies for strengthening planning and evaluation were also strong themes. Planning strategies mentioned included increasing involvement from staff in planning, the use of planning tools such as the Quality Improvement Program Planning System and more support from DHS in terms of "planning/evaluation templates", "planning processes" and "training". Suggestions for strengthening evaluation included increasing the resources put into evaluation, training, better use of evaluation tools, health promotion workers gaining additional research qualifications, and the development of links between community health and the academic sector.

Discussion

It is unsurprising that lack of resources should top the list of issues of concern identified by health promotion practitioners. The level of investment in health promotion and primary prevention by governments across Australia has remained at 1.7% of the total health budget since 1999, a level of investment that the Victorian government has itself described as "not enough".⁶ The Auditor General's report into health promotion in Victoria identified lack of resources as a barrier to effective health promotion for some community health agencies although it noted that others had made strong progress.⁴ Lack of resources is not just a question of funds: in research into the factors that stop people who have received health promotion training from implementing their learning in their workplace lack of time was identified as key barrier.⁷

The optimism expressed by some respondents that health promotion was moving up the political agenda is a view shared by Lin and Fawkes who argue that since the late 1990s a new policy space has been created for health promotion by increasing concern over the cost of medical care and labour productivity amongst decision makers in Treasury and other parts of government.⁸ Since its election in 2007 the federal Labor government has indicated an interest in preventative health. The National Preventative Health Taskforce (NPHT) was set up to develop a "comprehensive and lasting Preventative

Health Strategy". The vision of preventative health outlined by this taskforce includes a role for primary health care that largely focuses on health education and brief interventions by health professionals in the primary health care setting.⁹ The broader health promotion role of community health services of building local coalitions, influencing policy at a local level and fostering community action is not recognised by this discussion paper. Two of the core support structures outlined by the NPHT for effective prevention – community engagement and partnerships/collaboration – are the two strengths of health promotion in community health that were most strongly identified in this survey.

The Victorian Government has also outlined imperatives for health reform such as an ageing population, rising health care costs, an increasing prevalence of chronic diseases, and an overstretched health workforce, which they have said requires a renewed focus on prevention, including health promotion.⁶ The Victorian Government has called for a stronger emphasis on primary prevention, including the development of sub-regional "Healthy Living Partnerships". However the Victorian government's proposals do not mention a role for community health in the health promotion agenda despite the fact that DHS policy documents, including *Community Health Services – creating a healthier Victoria*¹⁰ and the Primary Care Partnerships strategy¹¹ outline a strong commitment to the role of community health services in health promotion. If community health is to benefit from increased interest in prevention it may need to become a stronger advocate for the importance and effectiveness of its role so that this is recognised at the state and federal levels.

A number of the other themes that emerged from the survey responses are in alignment with findings from previous studies. Keleher et al's study of the barriers to implementing learning from the DHS health promotion short course identified lack of understanding by managers and lack of managerial support as key barriers.⁷ In analyses of partnership working for health promotion, lack of management support has also been identified as a barrier.¹²

In general the capacity building strategies outlined by respondents were in alignment with the literature on capacity building for health promotion in community health. The

Regional Infrastructure for Improving Health Promotion (RIIHP) model developed by the Southern Metro Region of DHS following interviews with 45 health promotion practitioners, managers, academics and DHS program advisers outlined a range of strategies for capacity building. Many of these are in alignment with the responses to this survey including developing planning processes and policies, communication strategies, continuing workforce development, management support, and building alliances.¹³ More recently in 2003 DHS mapped and analysed capacity building strategies implemented in one region of Victoria. The key driving and resisting forces for successful capacity building that were found included communication with all levels of the system, active commitment and involvement of managers, clear and consistent vision and adequate resourcing for change.¹⁴ Finally, in 2006 as part of a consultation on health promotion priorities DHS asked consultation participants, which included community health staff as well as representatives of other agencies, what effective capacity building strategies they had implemented in their organisations. Responses included management commitment to health promotion, access to workforce development resources, organisational commitment to health promotion, the Quality Improvement Program Planning System, dedicated health promotion staff or health promotion outcomes built into all positions.¹⁵

Conclusion

Lack of resources was clearly identified as the major barrier to effective health promotion in community health. Health promotion practitioners strongly argued that increased investment is required to strengthen health promotion in the sector. The responses also suggest that to be successful at least part of any new investment needs to be directed towards addressing organisational and workforce barriers in the system. Organisational and workforce development are required to ensure that managers and workers in community health have an understanding of health promotion and possess the skills to support and/or undertake health promotion work. To benefit from increased interest in preventative health from governments the community health sector will need to articulate a strong argument for the contribution it can make if these barriers are overcome.

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