

The health promotion shift into Primary Health Organisations: Implications for the health promotion workforce

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ABSTRACT

INTRODUCTION: Reconciling the primary care sector's traditional concern for individual health outcomes with a population health approach is integral to the implementation of New Zealand's Primary Health Care Strategy, and a key challenge for health promotion in New Zealand. The purpose of this study was to examine the views of health promoters, their funders and managers toward the implementation of the Primary Health Care Strategy's health promotion agenda.

METHODS: Focus groups and interviews were carried out with 64 health promoters and 21 health sector managers and planners and funders over the 12 months beginning March 2008. Interview and focus group transcripts were analysed thematically.

FINDINGS: Primary Health Organisations (PHOs) have been perceived as both an opportunity and a threat to health promotion. The opportunity was seen to lie in the development of health promotion responsive to the needs of communities. Yet the numerous PHOs that emerged spread funding and capacity for health promotion thin, particularly amongst smaller PHOs.

CONCLUSION: The failure of the Ministry of Health to engage the health promotion workforce in the development and implementation of the Primary Health Care Strategy has led to a clear sense of vulnerability among health promoters. Ideological divisions between primary care and public health have been exacerbated by the restructuring of health promotion funding and delivery. Within non-governmental organisations and public health units concern continues to surround the legitimacy of health promotion approaches undertaken within the primary health care sector.

KEYWORDS: Health promotion; primary health care; health policy; Primary Health Organisations; New Zealand; restructuring

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Introduction

Reconciling the primary care sector's traditional concern for individual health outcomes with a population health approach is integral to the implementation of New Zealand's (NZ's) 2001 Primary Health Care Strategy (PHCS).^{1,2} It has created challenges, not only for primary care, but also for the health promotion workforce. The practice of health promotion has itself undergone change in recent decades, shifting from health education for behaviour change to working with groups to create social and physical environments

that support the health and well-being of communities.^{3,4,5} This emphasis on social environments contrasts with the individualistic health education models favoured by primary care physicians internationally.^{6,7} Current NZ government policy favours this personal health care model.⁸

International experience suggests that health promotion has proved complex and difficult to implement in an integrated fashion in primary care. Overseas, physicians experience constraints adopting health promotion approaches due to limitations in their own knowledge,

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available time and variable confidence in the evidence for behaviour change strategies.^{9,10} Among NZ general practitioners there is evidence of ambivalence toward health promotion and resistance to the often impractical expectations of its implementation.^{11,12}

Since the 1980s, non-governmental organisations (NGOs) and Public Health Units (PHUs) have worked collectively as 'providers' to address health promotion issues as diverse as workplace health, physical activity, diet, and sexual health. Philosophies of cooperation and partnership that experienced decline in the competitive contracting environment of the 1990s began to take precedence again in NZ's public health sector from the election of the Labour government in 1998.^{13,14} This renewed emphasis on collaboration was an important shift for health promotion bringing funding practices in line with the principles of the Ottawa Charter.³ The PHCS posed a new challenge for health promotion providers as health promotion formally entered the primary care sector.

The introduction of PHOs was part of an ideological shift to infuse primary care with population health principles, and included health promotion funding and community involvement in governance.^{15,16,17,18} While PHOs are allocated funding for health promotion in line with their population base, most NGOs are dependent upon government contracts to provide specific services, rendering the emergence of new providers a considerable threat. All PHOs around NZ have carried out health promotion programmes, though these have varied enormously, having included everything from targeting individuals with obesity or addressing poorly-insulated housing to broad community development.¹⁹

This paper examines the implementation of health promotion into the primary care sector in NZ, a process complicated by the numerous (81) PHOs that emerged, varying in size, philosophy, and their use of funds.^{17,18} Health promotion, which has traditionally sat within the public health sector in NZ, has largely been overlooked in policy research with a few notable exceptions.^{14,20} This paper draws on interviews and focus groups with health promoters and health

sector planners and funders to examine their responses, as stakeholders, to the implementation of the PHCS's health promotion agenda. Further, this paper describes the introduction of health promotion funding into PHOs and discusses the implications of that funding shift for relationships within the health promotion sector.

Methods

Applying a qualitative research methodology, health promoters and health sector planners and funders were recruited from five regions across NZ, defined by PHU jurisdiction. Regions were selected to capture ethnic and geographic diversity by including a range of urban and rural settings across the North and South Islands. One region was excluded from the study where the local PHU opted not to take part. As the largest employers of health promoters in NZ, PHUs were key to the sample. A minimum of 10 health promoters and six planners and funders of health promotion were initially sought from each region across a range of organisations (PHUs, NGOs and PHOs). An additional six individuals involved in planning and funding at the national level also were recruited.

Health-oriented NGOs, PHUs and PHOs were identified by telephone book or government listing. Health promoters were recruited through their organisations. Telephone contact was made to ensure the identified organisations employ health promoters prior to sending a written invitation to participate in the research. Follow-up phone calls were made to non-responders. A total of 21 planners and funders and 64 health promoters took part in the research, more than the initial 80 sought (see Table 1). Participation was highest amongst PHU employees and lowest amongst PHOs where limited budgets have led to a small health promotion workforce and their views may be under-represented in this research. Forty-nine of the country's 81 PHOs currently employ health promoters in at least a part-time capacity. Participants from PHOs commonly undertook management roles working across multiple general practices (Table 1).

In the 12 months from March 2008, 15 individual interviews, four group interviews (two

people in each) and 12 focus groups (of three or more individuals) were undertaken. Focus groups were the primary means of data collection with health promoters allowing participant responses to 'feed' off each other, producing a rich body of data. Individual and group interviews were undertaken with health sector planners and funders to promote in-depth discussion and more flexible scheduling.

The interviews and focus groups followed a semi-structured format allowing us to address the goals of the research project but providing the flexibility to incorporate relevant concerns of the research participants. Reflecting the inductive nature of qualitative research, the initial scope of the study, which sought to examine capacity building in health promotion, was expanded early on in the research process as research participants identified policy influences on health promotion practice.

Analysis allowed for the coding of both a priori themes consistent with the research questions and themes grounded in the data. A priori themes included the implications of current funding models on health promotion practice and relationships across organisations. In contrast, participants highlighted such issues as organisational change and Ministry responsiveness to concerns of the health promotion sector. Interviews and focus groups were audio-recorded, transcribed and later analysed using the software programme NVivo (a tool to assist coding of qualitative data). Data coding was a two-step process with initial coding compared for thematic consistency and recoded where appropriate. Differences in the views of health promoters and those involved in the funding and management of health and health care organisations were considered in comparing the two sets of data.

WHAT GAP THIS FILLS

What we already know: Little research has been undertaken on New Zealand's health promotion sector despite restructuring that has seen the implementation of health promotion into primary health care.

What this study adds: Ideological divisions and fear for the future of health promotion have been exacerbated by the failure of the Ministry of Health to adequately communicate the implications of restructuring for non-government organisations and public health units. This study highlights continued divisions that are undermining the collaborative approaches preferred by health promoters.

Ethical approval for the study was gained from NZ's Health and Disability Multi-Region Ethics Committee (MEC/08/10/EXP).

Findings

The establishment of PHOs with responsibility for delivering health promotion was a first for primary care in NZ, and was widely described by participants as a poorly implemented aspect of the PHCS. Health promotion funding was population-based, the per capita amount determined by the funding formula, with the usual amount being roughly two dollars per person per year. This funding was widely dispersed among the 81 PHOs established between 2002 and 2004. It was predominantly the larger PHOs, which had developed out of GP-oriented Independent Practitioner Organisations (IPAs), that received sufficient funding to employ health promotion staff.

District Health Board (DHB) participants described supporting PHOs in their different capacities, yet frustration with the PHO implementation process was evident: '...what's turned

Table 1. Distribution of participants across organisation type

	Primary Health Organisations	Non- Governmental Organisations	Public Health Units and DHBs	Other
Planners, funders and health promotion managers	5	10	6	0
Health promoters	1	14	47	2
TOTALS	6	24	53	2

out is the 60 or 70% of PHOs have got less than \$80,000 of funding so none of them are really in a position to build much capacity. They're certainly not in a position to have health promotion infusing itself into all other PHO activities.' (PA2:DHB:1). Health promotion within PHOs has taken on a myriad of forms differing not only in the focus of health promotion activities, but also in the way in which health promotion is administered. Reflecting government advice, some PHOs have elected to design and implement health promotion programmes themselves, others have collaborated with established community providers, while others chose to fund outside agencies to undertake health promotion.²¹

In this study, several health sector planners and funders were cynical of the ability of PHOs to reorient general practices toward health promotion with such limited resources. This point was reinforced by health promoters in smaller PHOs who noted their capacity to deliver programmes, particularly over large areas, was greatly constrained by their share of the funding dollar. A stronger population health approach was evident in the health promotion programmes of the participating three larger PHOs, where connections beyond the health sector were drawn upon to address Ottawa Charter goals of strengthening community action, building healthy public policy, reorienting health services, and creating supportive environments. The resources PHOs dedicated to reorienting general practices toward health promotion ranged considerably, as did the health promotion orientation and ideology of the practices with which they were associated, a point illustrated in the quote below:

We've got like 10 practices in our area and they vary in their size and the way they operate quite dramatically... we've got a couple who are saying 'we've been doing this for 20 years we don't need to be helped with anything'... And then you've got other ones that operate as a business and so you've got to be really careful about how you approach them. (PD2:PHO:1)

Some general practices were deemed by PHO participants to be forward-thinking, having a history of health promotion, while others continued to work within a personal health care framework,

emphasising health education, despite the population health goals embedded within the PHCS. Working across such a wide array of practices and philosophies emerged as an additional burden for several DHB planners and funders who were allocated responsibility under the PHCS to navigate this transition.

The introduction of PHOs: shaking up the sector

Minimal government consultation and a lack of communication during the planning and implementation of the PHCS was a complaint from many participants. Criticism most commonly fell on the Ministry of Health which, participants argued, had failed to bring together all relevant parties to discuss the future for the health promotion sector during the early years of the PHCS. It was mentioned that the Ministry of Health contracted out responsibility for the one national hui that took place in 2006.²² This limited engagement by primary care policy makers with the wider health promotion sector led to confusion about the relative role of each type of organisation (NGO, PHO, PHU) within the mosaic of health promotion providers in NZ, as the quotes below illustrate:

I think when the whole PHO health promotion thing was introduced everyone didn't sit around the table nationally, like, people got together and we talked about what health promotion would look like in PHOs... And it was back to personalities where we didn't want to work with each other. Plus all of that conflict about money as well. (C1:PHU:4)

I think there was a lot of angst about the unknown and it took some challenging of ourselves to understand that this was an opportunity as opposed to a constraint and to understand what we as a Public Health Unit are good at and can focus on and how does that sit alongside the relative who are trying to do the same thing and how does that complement each other... (PD1:PHU)

Despite the lack of clear health promotion planning associated with the PHCS implementation, the introduction of PHOs was described by most DHB planners and funders as an opportunity for health promotion. This opportunity was seen to lie in the community-based nature of PHOs

and their relatively light bureaucracy, with the potential to facilitate communication and responsiveness (in the form of funding) between the health sector and communities, as one participant depicted within their PHO: 'I think it's a great environment to be in and smaller, easier to move, less cumbersome than a huge, you know, capital organisation.' (PA1:PHO)

In contrast, many PHUs were portrayed as overly bureaucratic and struggling to respond to the emerging needs of communities. Others were more qualified in their optimism toward PHOs and again highlighted the challenges of implementing good health promotion programmes with minimal outside guidance:

'Well I'm- I think the PHOs are an opportunity and a risk. The opportunity is working with the communities. The risk is that we've got a whole lot of people working in there that are newly employed and don't understand health promotion...' (N6).

The effectiveness of health promotion programmes within PHOs was a point of contention amongst many participants and, while outside of the scope of the current discussion, opinions appeared connected to ideological differences in health promotion approaches. These differences are discussed in the following section.

Competition and collaboration in health promotion

Building collaboration and alliances between providers is an established health promotion strategy^{14,23} that can prevent the duplication of services and maximise the impact of health promotion initiatives where resources are limited. Participants' collaboration was described as integral to the success of health promotion through the sharing of knowledge, connections and resources. As one participant explained:

...one of the strengths we have as health promoters ...[is] working together on the ground at the coal face. So we don't need funding issues and competition ruining our focus. (B2:PHU:1)

Several participants expressed concern for the future of health promotion outside of PHOs,

fears that appeared to emerge from the lack of communication over the role of PHOs in the health promoter landscape and protectionist attitudes left over from the competitive funding of the 1990s.

In light of renewed ideologies of cooperation in the public health sector, several NGO participants described their surprise in discovering that local PHOs who had positioned themselves as health promotion providers were competing alongside them for contracts. The implications of this competition is discussed by participants in the quotes that follow:

...[W]ith the PHO being given contracts to let there's another obstacle to us as a health promoter because where they're getting the contracts, they let them, and we might get one or two of them—whatever—but there's another slice of the money off for the PHO and by the time it gets to us it's next to nothing. (A3:NGO:5)

There was a fear by many community groups that the PHOs would be given the responsibility of funding community groups... because they would have lost their independence and actually come under the PHO umbrella. (PB2:NGO:1)

For most health promoters, competition was deemed to be counterproductive to their work and they stressed the need for stronger relationships across the health promotion sector. PHO relationships with PHUs and NGOs varied widely. Cooperation to address health issues such as vaccinations were not backed up by coordinated health promotion approaches while many health promoters simply did not interact with their counterparts in other organisations, as elaborated on in the following quote:

...you'd think that seeing as we're a part of the same big organisation that our projects would somehow connect, support each other, yeah but we're not. They don't. (A1:PHU:2)

Explanations for the lack of working relationship varied substantially. Several health promoters indicated personality conflicts, particularly at the management level between PHOs and their own organisations, hindered cooperation and

stopped workers from ‘coming out to play’. Others explained the nature of funding prohibited contracting out services to other organisations and prevented collaboration, while others still highlighted ideological differences between organisations:

I think that the Maori PHOs, I think we probably work quite well with them because they sit within Maori providers. I don't think we work as successfully and probably what my dream was when I was working under that PHO... [a] health promotion strategy for the whole region would be awesome. But it boils down to trust and personalities. (C1:PHU:6)

The thing about PHOs is there's an aspect of them that's a business—this is our enrolled population ‘oh no you're that PHO well you can't really have our services because we're not funded to do that for you’. (D3:PHU:1)

The criticisms voiced by participants highlight the ideological divisions affecting relationships in the health promotion sector, which may connect back to long-held perceptions of general practices and their ability to adopt a population health approach. However, many PHO employees and general practice staff had pre-existing relationships with NGOs and PHUs that, ironically, appeared not to benefit from the PHCS with its funding arrangements for health promotion in primary care.

Discussion

This research has examined the implications of primary care reform, highlighting the effects of a poorly managed PHO transition on workforce relationships. The establishment of PHOs was the most recent in a series of health system restructuring that has changed the nature of health sector relationships in NZ. While an impetus towards market style competition in the early 1990s is noted by several authors to have eased,^{13,15} funding for many NGOs is still largely dependent on contestable contracts. The addition of PHOs to the provider landscape renewed competition and funding uncertainty for several NGO health promoters, who reported finding themselves with a new competitor.

These findings are consistent with those of Malcolm et al.²⁴ who noted that in the competitive environment of the Public Health Commission era, the desire for collaboration was strongest amongst existing networks, whereas new competition from general practitioners was treated with ‘considerable suspicion.’

For a sector that relies on collaboration, management of the PHCS implementation stifled relationships between PHUs and NGOs and failed to address differences in approaches between PHOs and the rest of the health promotion sector. Central government was deemed to have inadequately considered the implications of restructuring on this sector. This failure served to exacerbate the confusion and fear over the future for NZ's health promotion providers. Collaboration, deemed central to health promotion practice, was widely expressed as lacking between PHOs and the rest of the health promotion sector. The lack of collaboration was attributed to personality conflicts, the organisation of funding, and ideological differences. While this paper does not seek to evaluate the quality of health promotion work within PHOs, this research does identify how a policy aiming to expand health promotion and population health approaches in primary care had unintended consequences.

Planners, funders and managers of health promotion were quite receptive, in this study, to the shift of health promotion into primary care. These participants saw PHOs more as an opportunity for the development of responsive health promotion programmes, free from the red tape present in many government agencies. The PHCS had allowed for considerable freedom in the development of health promotion programmes within PHOs. Less positively, this ‘freedom’ was portrayed by many participants as a lack of policy planning or guidance. The extensive number of PHOs established, with many small ones having limited financial capacity and expertise for effective health promotion, resulted in health promotion efforts being dispersed rather than coordinated.

This research has examined the stakeholder responses to the establishment of health promotion within PHOs. Its findings are particularly

pertinent in light of recent health policy changes; cuts to health promotion staff in some of the country's PHUs and PHOs, the emergence of very large PHOs, and the current government's pursuit of Integrated Family Health Centres.²⁵ The implications of these changes on the health promotion workforce, including their numbers and training needs, are a focus of current research by the first author. While merging PHOs may result in increased capacity for health promotion, it may come at the risk of diminished connections to local communities. The community development approaches adopted by the majority of health promoters in NZ are as relevant to primary health care delivery as they are to the work of public health units. In focussing on PHOs, this paper has not addressed the important role that health promoters play in addressing the social and economic determinants of health that sit outside the formal health sector.

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COMPETING INTERESTS

None declared.