ORIGINAL SCIENTIFIC PAPER

SHORT REPORT

# Health promotion funding, workforce recruitment and turnover in New Zealand

**Sarah A Lovell** BSocSc, MSc(Hons), PhD;[1] **Richard Egan** MPhil, PhD;[2] **Lindsay Robertson** BSc (Hons) Psych, MPH;[2] **Karen Hicks** RGN, BSc(Hons), MA Health Promotion (Hons)[3]

[1] School of Health Sciences, University of Canterbury, Christchurch, New Zealand

[2] Department of Preventive and Social Medicine, University of Otago, Dunedin, New Zealand

[3] Health Promotion Forum of New Zealand

## ABSTRACT

**INTRODUCTION:** Almost a decade on from the New Zealand Primary Health Care Strategy and amidst concerns about funding of health promotion, we undertook a nationwide survey of health promotion providers.

**AIM:** To identify trends in recruitment and turnover in New Zealand's health promotion workforce.

**METHODS:** Surveys were sent to 160 organisations identified as having a health focus and employing one or more health promoter. Respondents, primarily health promotion managers, were asked to report budget, retention and hiring data for 1 July 2009 through 1 July 2010.

**RESULTS:** Responses were received from 53% of organisations. Among respondents, government funding for health promotion declined by 6.3% in the year ended July 2010 and health promoter positions decreased by 7.5% (equalling 36.6 full-time equivalent positions). Among staff who left their roles, 79% also left the field of health promotion. Forty-two organisations (52%) reported employing health promoters on time-limited contracts of three years or less; this employment arrangement was particularly common in public health units (80%) and primary health organisations (57%). Among new hires, 46% (n=55) were identified as Māori.

**DISCUSSION:** Low retention of health promoters may reflect the common use of limited-term employment contracts, which allow employers to alter staffing levels as funding changes. More than half the surveyed primary health organisations reported using fixed-term employment contracts. This may compromise health promotion understanding, culture and institutional memory in these organisations. New Zealand's commitment to addressing ethnic inequalities in health outcomes was evident in the high proportion of Māori who made up new hires.

**KEYWORDS:** Employment; health policy; health promotion; public health; workforce

## Introduction

Last century's 'golden age' of public health, with its rapidly falling mortality rates, is behind us. Whereas emergency preparedness has been reconstituted as an international priority in the wave of terrorism, disasters and new pandemics,[1] government funding and commitment to less urgent public health challenges has waned internationally, including in New Zealand (NZ).[2,3] Increased investment in local public health units, however, may reduce mortality from preventable causes and lower infectious disease morbidity.[4,5]

Amidst concerns of funding cuts in the health promotion field, we undertook a nationwide survey of health promotion providers to identify trends in recruitment and turnover in NZ's health promotion workforce. Consistent with international trends,[6] the NZ government has emphasised the need for a skilled and competent public health workforce. Recent government investment has introduced public health competencies and leadership training programmes, while the Health Promotion Forum of New Zealand has been instrumental in establishing a professional society for health promoters.[7] However, public

J PRIM HEALTH CARE 2015;7(2):153–157.

**CORRESPONDENCE TO:**
**Sarah Lovell**
School of Health Sciences, University of Canterbury, PB 4800, Christchurch 8140, New Zealand
sarah.lovell@canterbury.ac.nz

health providers face challenges from the well-entrenched neo-liberal ideologies of individual responsibility, funding constraints, and a tertiary-oriented health sector,[6,8] and as a result, health promoters commonly perceive themselves to be undervalued by policy makers and clinicians.[9,10] This research contributes to the few empirical studies on the public health workforce.[6]

The health promoter workforce in NZ has been reshaped by two key policy developments: the establishment of primary health organisations (PHOs) and Whānau Ora. The Primary Health Care (PHC) Strategy[11] established PHOs, within which health promotion works alongside community clinical services.[9] The PHC Strategy's aspirations are explicitly health promoting, aiming to improve health by working with communities and Māori, the indigenous people of NZ, and addressing health inequalities locally.[11] PHOs were mandated to undertake health promotion with tagged funding; while this community health focus changed with the National-led coalition NZ government in 2009 to disease-focused targets, PHOs remain and their health promotion workforce continues to grow. A further government initiative started in 2010, Whānau Ora, aligns with health promotion in aiming to 'de-silo' health, education and social service delivery.

## Methods

Health promotion in NZ is primarily provided by public health units, PHOs, and non-governmental organisations (NGOs). In this study, a census of all health sector health promoter employers in NZ was undertaken; 160 organisations were identified through networks and online listings as eligible to participate. All organisations with a health or health care focus, employing one or more health promoter(s) as at 1 July 2010 were deemed eligible, and eligibility was confirmed through telephone contact with receptionists or health promotion managers. The survey was developed through a review of existing literature and tailored to a NZ context to reflect NZ data systems, address Māori interests, and incorporate NGOs and PHOs.[3] Between September and October 2010, health promotion managers within each organisation were invited to complete the survey, drawing on their knowledge of workforce recruitment/termination, and funding changes. Managers completed personal questions about former employees, such as ethnicity and reason for resigning. Reminder letters and phone calls were made to non-responders. Analysis of the data was conducted using SPSS version 19.0, with descriptive statistics being the primary output, consistent with similar studies.[12] Qualitative data

*Table 1. Health promotion funding and employment in 2009–10 by organisation type*

| Organisation type | Overall response rate % | Change in NZ government funding for health promotion 2009/10 | Organisations with unfilled health promoter vacancies at 1 July 2010 | | | | | Organisations employing health promoters on time limited contracts % |
|---|---|---|---|---|---|---|---|---|
| | | | 0 vacant FTEs % | 0.1–2.0 vacant FTEs % | 2.1–4 vacant FTEs % | 4.1+ vacant FTEs % | Total Responses % | |
| **Primary health organisation** | 45 (n=22/49) | 1.8% | 81 (n=17) | 14 (n=3) | 5 (n=1) | 0 (n=0) | 100 (n=21) | 57 (n=12) |
| **Public health unit** | 83 (n=10/12) | -11.3% | 30 (n=3) | 20 (n=2) | 40 (n=4) | 10 (n=1) | 100 (n=10) | 80 (n=8) |
| **Non-governmental organisation** | 53 n=(47/88) | 7.2% | 78 (n=36) | 15 (n=7) | 7 (n=3) | 0 (n=0) | 100 (n=46) | 47 (n=21) |
| **District health board or other governmental organisation** | 55 n=(6/11) | -17.9% | 40% (n=2) | 40 (n=2) | 20 (n=1) | 0 (n=0) | 100 (n=5) | 20 (n=1) |
| **Total** | 53 (85/160) | -6.3% | 70 (n=58) | 17 (n=14) | 11 (n=9) | 1 (n=1) | 99 (n=82) | 52 (n=42/81) |

FTEs Full-time equivalent

was analysed thematically, using an abbreviated general inductive approach. The analysis sought to characterise new health promoter 'hires' and identify the influence of funding approaches on employment by comparing organisations (particularly Māori and mainstream providers, and among public health units and other providers).

## Results

Survey responses were received from 53% of the country's 160 health promotion providers. Response rates ranged from 83% of the country's 12 regional public health units (the largest employer of health promoters), to 45% among PHOs (see Table 1). In the 2009–10 year, 48% (n=38) of responding organisations were fully reliant on government funding, 19% (n=15) received no government funding, while the remainder were partly funded by the government.

Forty-nine respondents provided the dollar value of their budgets for both 2009 and 2010. A collective decline of $2,441,959 (6.3%) in government funding was reported over the period. The decline was attributed to substantial funding cuts within several large DHBs/other government organisations (see Table 1). Most organisations (n=24) reported no change in funding, while 22% (n=11) reported declines in 2010. Twenty-nine percent of respondents (n=14) reported increased government funding. Māori organisations and NGOs were least affected by funding changes, with none of the 13 self-reported 'by Māori for Māori' organisations reporting declines, and three reporting increased government funding. Across all responding organisations, a 7.5% decrease in health promoter positions (equalling 36.6 full-time equivalents [FTE]) was reported between 2009 and 2010.

### Recruitment of health promoters

Information was provided on the qualifications and characteristics of 124 health promoters recruited during the 2009–10 financial year by 62 organisations. Māori comprise 14.9% of NZ's population,[13] but among new hires 46% (n=55) were identified as Māori, 38% (n=45) as NZ European, 8% (n=9) Pacific, and 13% (n=15) were classified as 'other' ethnicity (percentages do not add to 100 due to ethnicity recording allowing identification with more than one ethnicity). When hiring, several respondents indicated that speaking the Māori language was a necessary skill, or that experienced Māori or Pacific health promoters with strong connections to their local community were sought.

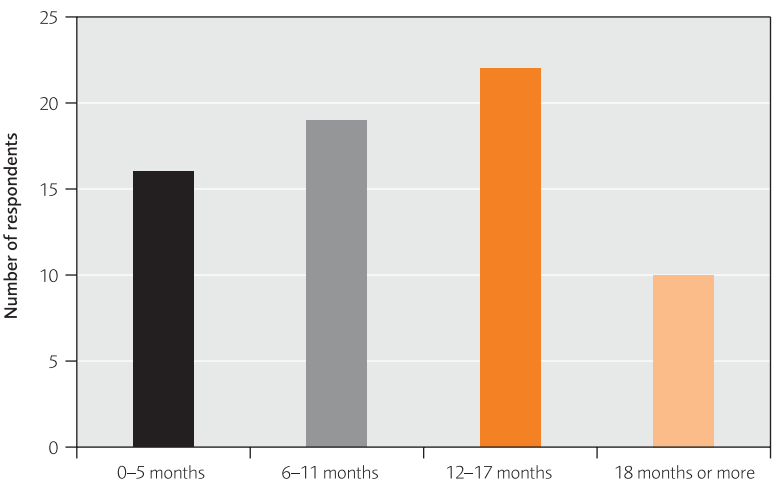
Of the 78 organisations responding to the recruitment questions, most (68%; n=53) reported little difficulty recruiting staff with appropriate qualifications and experience during the previous year. However, qualitative responses identified challenges finding people with an appropriate balance of experience, skills, qualifications and knowledge. Approximately half (n=32) reported that newly hired health promoters require additional support and supervision for 12 months to develop the skills, knowledge, and networks necessary for their new role (see Figure 1). Around a third of new hires (36%) had no previous work

### WHAT GAP THIS FILLS

**What we already know:** Health promoters are a critical component of the public health workforce and, increasingly, the focus of workforce development.

**What this study adds:** The field of health promotion appears to be in the midst of a retention crisis potentially undermining training and other workforce investments.

*Figure 1. Time period managers report supporting new health promoters to develop the skills, knowledge and networks necessary to work independently (n=67)*



experience in health promotion. Differences between organisations were evident, with new hires to public health units tending to be educated to a higher level and receiving a higher starting salary than NGO hires, including Māori organisations (see Figures 2 and 3). Lack of available funds was the major challenge faced by organisations recruiting health promoters, impacting on the competitiveness of salaries offered and opportunities to hire.

## Termination and limited-term employment contracts

In total, respondents indicated that 231 health promoters (of varying FTE status) had left their organisation in the 2009–10 financial year. Information on the circumstances under which health promoters ceased employment with their organisation was requested. Data on 95 health promoters who left their roles indicated that approximately 72% (n=68) resigned, 16% (n=15) were made redundant or had their position disestablished, and 13% (n=12) left under other circumstances. Amongst individuals who left their jobs, 79% left the field of health promotion. Reasons for resigning were provided for 55 health promoters, with the most common reason given being personal circumstances (n=15), desire to travel or moving to a new location (n=12), and offer of another employment opportunity (n=11). Forty-two organisations (52%) reported employing health promoters on time-limited contracts of three years or less (see Table 1); this employment arrangement was particularly common in public health units (80%) and PHOs (57%).

Respondents were asked to comment on any other issues affecting the employment and retention of health promoters. Most commonly, responses (n=19) centred on changes to health promotion funding, with short-term contracts

*Figure 2. Distribution of starting salaries of recently employed health promoters by ethnicity—NZ European/Other (n=60) versus Māori (n=49)*

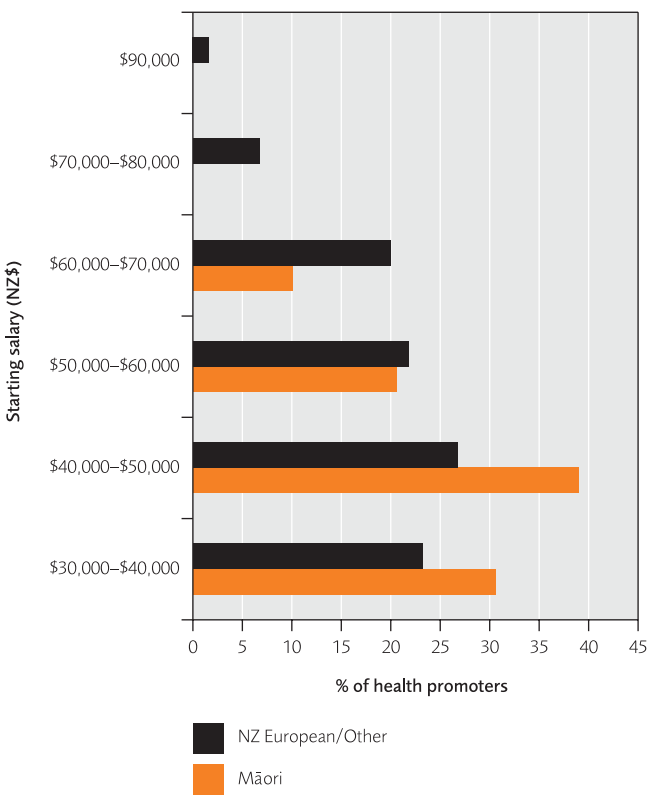
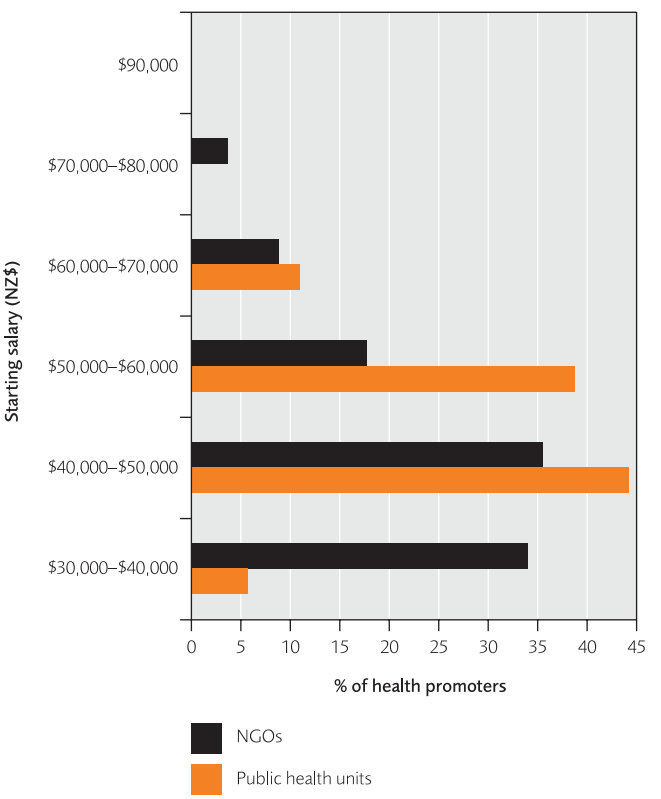



*Figure 3. Distribution of starting salaries of recently employed health promoters in public health units (n=18) and NGOs (n=56)*



not being renewed and declining funding for new hires. Organisational-level restructuring was cited by 15 participants as having had an effect on the recruitment or retention of staff. Changes to government policy were also raised, with four participants suggesting a shift in focus to clinical care caused uncertainty about the future of health promotion and paralleled concerns around uncertainty of funding within PHOs.

## Discussion

This research contributes empirical data on the state of employee turnover in the NZ health promotion workforce. Despite government commitment to up-skilling the public health workforce, in the 2009–10 financial year 79% of health promoters who left their jobs also left the field. In turn, 36% of new hires were new to health promotion, representing a significant cost in training, as managers commonly supported staff for 12 months to begin working independently. This turnover may reflect the heavy use of limited-term employment contracts in the sector, which allow employers to increase and reduce staffing levels as funded programmes and their associated skill requirements change. Over half of PHOs reported using fixed-term employment contracts, which may compromise the development of health promotion understanding, culture and institutional memory in these organisations and may undermine the aim of the PHC Strategy. Following widely publicised cuts to health promotion programmes, a 6% decline in government funding in the 2009–10 financial year was experienced across responding organisations, although the largest share (49%) experienced no change. Māori organisations appeared to be largely unaffected by funding cuts, possibly due to the new government-funded Whānau Ora (family-centred) approach to social service delivery, which is being implemented primarily by Māori organisations. More cynically, the focus of Whānau Ora on service coordination can be seen as individually driven, shifting funding away from upstream health promotion approaches. NZ's commitment to addressing ethnic inequalities in health outcomes is evident in the high proportion of Māori (46%, n=55) who made up new health promoter hires. Yet, our data suggest that Māori organisations may not have the resources to recruit staff with the equivalent education and experience as those recruited by government organisations.

We undertook a census of health promotion providers in New Zealand and a strength of this study is the inclusion of NGOs. However, low response rates, particularly among smaller health promotion providers, limits the representativeness of the dataset. In addition, the survey relied on managers to report accurate data whereas surveying the health promoter workforce directly may have improved the quality of the personal data collected.

### References

1. Lurie N, Wasserman J, Nelson CD. Public health preparedness: evolution or revolution. Health Aff (Millwood). 2006;25(4):935–45.
2. Daube M. A bleak outlook for public health? Aust N Z J Public Health. 2012;36(6):503–4.
3. National Association of County and City Health Officials (NACCHO). Local Health Department job losses and program cuts: findings from January 2012 survey. Washington: NACCHO; 2012.
4. Mays GP, Smith SA. Evidence links increases in public health spending to declines in preventable deaths. Health Aff (Millwood). 2011;30(8):1585–93.
5. Erwin PC, Greene SB, Mays GP, Ricketts TC, Davis MV. The association of changes in local health department resources with changes in state-level health outcomes. Am J Public Health. 2011;101(4):609.
6. Beck AJ, Boulton ML. Building an effective workforce: a systematic review of public health workforce literature. Am J Prev Med. 2012;42(5):S6–S16.
7. Ministry of Health. Te Uru Kahikatea: The Public Health Workforce Development Plan 2007–16. Wellington: Ministry of Health; 2007.
8. Scriven A, Speller V. Global issues and challenges beyond Ottawa: the way forward. Promot Educ. 2007;14(4):194–8, 255–9, 269–73.
9. Lovell S, Neuwelt P. The health promotion shift into primary health organisations: implications for the health promotion workforce. J Prim Health Care. 2011;3(1):41–7.
10. Wise M, Signal L. Health promotion development in Australia and New Zealand. Health Promot Int. 2000;15(3):237–48.
11. Ministry of Health. The Primary Health Care Strategy. Wellington: Ministry of Health; 2001.
12. Phoenix Research. Public Health Workforce Research: survey of organisations and individuals. Auckland: Phoenix Research, 2004.
13. Statistics New Zealand. New Zealand's major ethnic groups continue to grow. 2013 Census QuickStats abut culture and identity. [cited 2014 July 17]. Available from: http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-culture-identity/ethnic-groups-NZ.aspx

**ACKNOWLEDGEMENTS**
The authors would like to acknowledge the important contribution of Lesley Reeves to the data collection for this project.

**FUNDING**
The authors gratefully acknowledge the Dunedin School of Medicine, University of Otago for funding this project.

**COMPETING INTERESTS**
None declared.