contributions and readership. We feel that the next phase of the Journal needs to focus on continuing improvements to the overall quality of the Journal and expanding the readership.

We would like to add two objectives:

- To improve the quality of health promotion practice through improved quality of reporting of research and evaluation.
- To extend the impact of research and evaluation on policy and practice.

We see the Journal as contributing to building the body of knowledge of high quality evidence and wish to ensure that it is a tool for teaching. The Journal should also aim to provide better evidence for policy changes and for advocacy, to provoke thought and to facilitate discussion about specific issues, and to influence stakeholders in the field.

We see at least three clear priorities for the Journal. First, the professional and academic standards of the Journal should aspire to meet the criteria for indexing by electronic databases (e.g. Medline, EMBASE, etc). This would mean focusing on improving the quality of articles published, which would require an increase in the quality of submissions received. Better-quality papers would also increase the Journal's readership.

Second, the Journal should make a significant contribution to the base of evidence for health promotion and support the translation of research into practice. This will mean focusing on evidence to support interventions to address the multi-factorial determinants of health and interventions to reduce inequalities in health. It will mean improving the standard of published program evaluations and qualitative and quantitative research, with particular emphasis on interventions that acknowledge the context and constraints on health promotion in the real world. We encourage regular reviews of evidence for effectiveness of strategies, dialogue and discussions of different methodological approaches necessary to build evidence, and experiences of applying research into practice.

Third, we see the Journal as developing a broader audience. Many sectors are involved in health promotion and there are many perspectives that are necessary to the success of the work. This means inviting relevant contributions from a range of professional fields and from a range of contributors (eg policy makers, practitioners from diverse sectors and agencies, teachers and researchers). We see that health promotion will be more effective if it works from a broad base: health promotion is in the business of influence and empowerment not only the generation of new knowledge. We plan to disseminate information from the Journal proactively to the Australian media to promote the Australian Health Promotion Association (AHPA) and the content of the Journal.

Longer-term directions include focusing on specific topics in theme issues of the Journal, as well as increasing the level of interaction between readers and authors. This will involve greater use of web-based technology and rapid-response publication. We will seek to engage more actively with the APHA members and to encourage interaction among members.

We look forward to working with the authors, reviewers, readers and production team in this next phase of the *Health Promotion Journal of Australia.*

The health promotion workforce and workforce development

Marilyn Wise

A knowledgeable, skilled health promotion workforce is a key component of the capacity needed by nations to promote the health of their populations. The nature of health promotion (the discipline or area of practice), however, makes workforce development a complex issue. Questions such as who is in the health promotion workforce, what kinds of knowledge and skills they need, and what policy and organisational support they require, have not yet been answered definitively.

There have been significant efforts within Australia, particularly (although not only) over the past decade, to develop a knowledgeable, skilled workforce that has the capacity to design, deliver, and evaluate effective interventions to address public health problems. These efforts have focused, principally, on professionally preparing those who work in designated health promotion positions primarily in the health sector, including community organisations (such as Aboriginal Medical Services) and health-related NGOs such as the National Heart Foundation.

Over the past decade, the National Public Health Partnership has overseen the development of nationally agreed competency standards, and the Public Health Education and Training Program has been the catalyst for the development of a national set of core learning outcomes for tertiary education in public health, including health promotion. The National Health and Medical Research Council has developed a national training and employment strategy for Aboriginal and Torres Strait Islander health workers and professionals working in Aboriginal and Torres Strait Islander health.

The same period has seen the development of considerable infrastructure to provide preparatory and ongoing professional education for health promotion practitioners and researchers, using a variety of methods of delivery. Considerable effort has also been made to provide other health professional groups with knowledge and skills in health promotion relevant to their roles.

In this issue of the Journal, four papers present perspectives on

the current situation in the health promotion workforce. The papers raise important questions. What qualifications do current practitioners have? How do these compare with the core competencies identified by the field and with the relevant components of the core functions of public health? What are practitioners doing to extend their knowledge and skills over the course of their careers in health promotion? Conversely, in what ways are educational institutions testing their teaching programs against the core learning outcomes, and are employers using the core competencies as standards against which to assess employees' performance and then, to identify directions for professional development?

Are there real differences in the competencies required by urban and rural practitioners? Are there differences in the levels of competence demonstrated by urban and rural practitioners? And if so, why?

In what ways do practitioners believe that credentialling would help to improve the effectiveness of health promotion practice in Australia? What are the strengths and weaknesses of becoming a 'closed' professional group – and of remaining an 'open' professional group?

What are the roles of clinicians in promoting health? What is needed to ensure that they incorporate effective health promotion into their routine practice?

For the future, challenges lie in several directions. First, what are the priority health and social outcomes to be addressed? Few would disagree that the achievement of equity in health and social outcomes across the population is one of the greatest contemporary challenges for the health sector in general and health promotion in particular. Creating social, economic and environmental conditions that support and sustain the health of populations is the focus here. What role can the health promotion workforce (as one of many workforces) play in this?

Second, identifying and applying evidence to support actions that address equity effectively is a challenge, in part because the evidence is scarce and, often, relatively weak (from a public health science viewpoint). This, in turn, points to the need for the health promotion workforce to contribute to building the evidence, including developing and adapting research methods to fit the questions that need to be answered.

Third, creating 'conditions for health' will necessitate influencing public policy in addition to 'health' policy – at local, state, national and global levels. This in turn implies greater involvement in the political processes that govern society.

Fourth, this also implies a significant shift in emphasis from 'community participation' or consultation to the development of structures and processes that overcome social exclusion and engage all parts of communities in decision making about problems, solutions, resource distribution, and in accounting for progress.

Fifth, in relation to current practice, a further challenge is to increase the scale and intensity of health promotion interventions that have been effective – moving beyond projects to create systems that act routinely, systematically, and consistently to sustain change.

Clearly, it is not sufficient to simply identify these as challenges for the workforce. The ability of the workforce to 'deliver' depends not only on individuals having the 'right' knowledge and skills – there is parallel need to build the organisational capacity of the education and health sectors (particularly) to enable and support the changes in focus and practice. It also depends on our ensuring that 'equity begins at home' – that our own workforce includes and is advised by members of socially excluded communities; and that we commit to achieving 'equitable outcomes' with explicit goals/targets/indicators and that we account publicly for progress.

It is important that these issues be debated through the pages of the journal. It is vital that there be ongoing review and discussion of the 'work' required of the health promotion workforce – to ensure that there is a good 'fit' between the two. It is also essential that the Australian Health Promotion Association contributes to building the organisational capacity needed to ensure the preparation and ongoing development of the health promotion workforce.