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Letter

Creating a sustainable health promotion workforce in Australia: a health promoting approach to professionalisation

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Australia currently has a deregulated health promotion workforce;[1] however, internationally, there have been moves to regulate health promotion and establish it as a specialist discipline.[2,3] Regulation is seen as a way to ensure that health promotion expertise is recognised as an important component of the preventive workforce,[4] providing a mechanism to protect community and industry interests by ensuring that practitioners meet minimum qualifications and demonstrate ongoing fitness to practice.[5] It confers a 'specialist' label on practitioners who gain 'ownership' of the field.[6] It also seeks to strengthen the workforce, and tends to bring prestige, influence and financial rewards to its members.[4,6]

In 2011 the Australian Health Promotion Association (AHPA) commenced exploring the options, benefits and costs of developing and implementing a professionalisation model in Australia versus maintaining the status quo (i.e. maintaining a deregulated health promotion workforce). Consultation with a large sample of AHPA members and key stakeholders (government and non-government departments, health services, Aboriginal health, industry and professional associations and students) obtained opinions on the benefits and challenges associated with various regulation models.

The consultation generated 15 professionalisation objectives and evaluated the suitability of 11 regulatory models by scoring the perceived ability of each model to meet the 15 objectives. A 'Y' for 'yes' and 'M' for 'maybe' indicated whether the regulatory options would achieve the respective objective. Entries were not recorded for a 'no'. Two points were awarded for 'Y', one point for 'M', and the scores tallied. Higher scores indicated a higher likelihood that the model would achieve the stated objectives.

The five highest-scoring options were: certification (22 points); general legislation and common law (19 points); accreditation (17 points); continuing professional development (16 points); and economic incentives (12 points) (Table 1). Further consultation with 158 AHPA members and stakeholders gathered feedback on the certification model, the level of support, impact on job role and career pathways, risks associated with implementation and opportunities.

The current arrangement for the Australian health promotion workforce is a deregulated model based on market forces. This scored only two points. Certification with a requirement for continuing professional development was identified as the best model to achieve an expert and growing health promotion workforce and increased professional recognition. However, a range of issues related to certification were identified including an intrinsic clash of values between a profession that is based on principles of inclusiveness and diversity and professionalisation models that by definition must be, at least, in part exclusionary.

Consultation participants generally agreed that the health promotion workforce had principles, knowledge and skills that qualified them as 'specialists' in health promotion. However, the view was also expressed that because health promotion comprises a diverse workforce, there is a broader view within the health sector that health promotion is 'everybody's business' and not a specialised area. While the exact composition of the health promotion workforce is unknown, AHPA membership shows an eclectic mix of professional backgrounds that includes social work, health science, nursing, dietetics, occupational therapy, research and population health and community development.

Research in South Australia with health promotion workers from a range of backgrounds and experience highlighted the lack of health promotion specialisation as an issue and the importance of a clear career pathway. The study mooted some form of professional status as a possible solution to both career security and a more prominent identity for health promotion practitioners. It was also suggested this would contribute to greater professional recognition.[7]

Table 1. Score for regulatory model achieving professionalisation by objectives

Y = 'Yes' – model will achieve professionalisation objective (score 2 points); M = 'Maybe' – model will achieve professionalisation objective (score 1 point); Blank = model will not achieve professionalisation objective (score 0 point)

Identified professionalisation objectives	Regulatory models										
	Certification[a]	Self-regulation Accreditation[b]	Continuing professional development[c]	Negative licence No entry[d]	Negative licence Sanction[e]	Incentives and market Economic[f]	Incentives and market Fiscal[g]	Market[h]	Deregulation General legislation[i]	Deregulation Private[j]	Deregulation Industry[k]
Promote evidence informed practice	Y	Y	Y						M		M
Create entry standards to the profession	Y	Y							Y		M
Maintain currency of knowledge	M	M	Y		M				M		M
Ethical conduct and behaviour standards	Y		M		Y				Y		
Attract students to health promotion education	Y	Y				Y	Y		Y		Y
Increase health promotion university places						Y	Y				
Create more pathways to entry (dual qualifications)	Y	Y	Y	Y					Y		
Define and expand the VET level workforce						Y					
Convert more health promotion graduates to employment	Y	Y				Y			Y		Y
Improve retention	Y	M	Y			Y			M		M
Attract qualified international health promotion practitioners	Y		Y	Y		Y			M		M
Ensure supply chain for health promotion workforce is flexible and responsive	Y	Y	Y	Y					M		
Establish health promotion within employment awards	Y	Y	Y						Y		
Align/exceed wages with allied health practitioners	M	M	M						Y		
Market health promotion as a career of choice								Y		Y	
Total score	22	17	16	6	3	12	4	2	19	2	9

Regulatory models: a = credentialing individuals; b = approving tertiary courses; c = retain currency through ongoing training; d = no screening before beginning practice; e = legislated sanctions for improper conduct; f = pricing incentives to influence demand; g = taxes and subsidies to influence demand; h = market forces select out providers; i = common law imposes restrictions (e.g. employment awards); j = consumer groups and media influence demand; k = industry schemes certify providers (e.g. recommended providers).

Key challenges for the development and implementation of a certification model for health promotion include: moving from a collective of people working in health promotion to establishing the health promotion practitioner role; ensuring the health promotion strengths created through the involvement of broader health and non-health workforces are retained; and acknowledging that many other people are working in health promoting ways and their contributions are valued.

The conflicted positions of wanting recognition of qualifications and expertise (i.e. an exclusive model) versus the desire for inclusivity (i.e. valuing workforce diversity) have created a major challenge for the development of an agreed model. Rather than conceding to these challenges and dismissing the concept of professionalisation, possible solutions to the dichotomy of these positions have been discussed. Participants in this project's consultations favoured a competency-based model, which is consistent with previous findings that health promotion practitioners perceive competencies help to differentiate health promotion from other allied health professions, and provide a framework for credentialling.[8]

Conclusion

The consultation identified that if regulation is to occur in Australia and be embraced by the broader health promotion workforce, the health promotion industry needs an innovative model that is flexible and responsive as compared to current 'exclusive' professionalisation models. Ideally it must maintain the core values and objectives of health promotion such as inclusion and equity.

While other international regulation projects have been required to establish 'domains of practice' or competencies,[2,3] this has already been achieved in Australia with the development of AHPA Core Competencies for Health Promotion.[8] This project was able to move beyond defining health promotion competencies and consider questions associated with models of regulation.

Traditional certification, that typically includes tertiary qualifications as a mandatory requirement, was considered problematic by key stakeholders due to its exclusionary nature. An alternative approach is to incorporate a competency based certification model that acknowledges specialist areas of health promotion and other agreed criteria. This would address the concerns raised during the consultations and would be a unique form of regulation that has not been implemented in the Australian context.

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