

Health promotion in PHOs: Should we differentiate 'health promotion' and 'health-promoting ways of working'?

'Think Piece', Doone Winnard, October 2006

The purpose of this document

Much need and a limited number of workers means that most of the time those involved in health promotion in PHOs have to be busy 'getting on' with planning and implementing their health promotion work. This can leave little time for thinking about the philosophy of how health promotion in PHOs is supposed to help achieve the goals of the Primary Health Care Strategy. Many participants at the national hui in Wellington advocated for increased opportunities to step back and reflect on their practice. This 'think piece' is offered as something people may choose to dissect and respond to when they do have such an opportunity, and such feedback would be most welcomed.

I am very conscious that this document is only considering one aspect of health promotion in PHOs, internal organisational development work. Obviously there is a huge amount of other work being done by health promoters in PHOs towards the goals of the PHCS that is not even touched on. The particular obvious lack is working in and with the community, including organisational development work in that context. The lack of discussion about that is not because I don't see that work as central for health promotion in PHOs. Rather the close interface with primary care clinicians in PHOs is one that is new for many health promoters, one that was highlighted at the national hui by the Ministry as being important, and one which I have been pondering with personal interest because of my background as a GP.

The stimulus for this document

Over the course of this year I have been engaging with some of those involved with GP College activities around the subject of health promotion in PHOs, including presenting at their recent annual conference. Previous reviews of the interface of public health and primary care have often emphasised the differences in the 'world views' of those on either side¹. However it is my experience that in trying to understand the role of the health promotion funding stream in PHOs, there is significant good will to move beyond this view that public health and personal care approaches represent two very different world views towards a shared understanding. This has led me to ponder further one of the tensions we began to explore at the hui in Wellington, between the need for health promotion as a profession to be better validated and recognised as having a unique contribution to make in its own right, and wanting to encourage all those in the world of primary care to be increasingly 'health-promoting' in their ways of thinking and working. I think it is a challenge to articulate this tension, without seeming to advocate for a return to emphasising the differences.

Is one potential way to articulate this tension to differentiate between

- (a) 'health promotion', to be planned and undertaken by a skilled workforce with health promotion competencies (as defined by public health understandings of the term health promotion), and
- (b) 'health-promoting ways of working' by all in the PHO, to be facilitated/encouraged, recognised/validated by health promoters?

How might we differentiate these aspects of 'health promotion in PHOs', and therefore clearly define a role for those with formal health promotion expertise, while still valuing all the efforts and backgrounds people bring to a wider picture of health-promoting activity in the primary care setting? Does this concern originate from past perceptions that health promotion needed to distance itself from individually-focused clinical activity so it was not swallowed up by the overwhelming clinical need, and if so is there still some

¹ Bhopal, R (1995) *Public health medicine and primary health care: convergent, divergent or parallel paths?* Journal of Epidemiology and Community Health 49: p. 113 – 6; Ministry of Health (2002), *Public health in a primary health care setting*. Public Health Directorate, Ministry of Health: Wellington.

validity to this perception? **How do we express this concern, and advocate for the used of health promotion funding in PHOs for wider, collective activities, but not seem to be advocating for siloed rather than integrated activity?** How might the different aspects of health promotion in PHOs connect with the day-to-day activities of general practice teams in PHOs, while not consuming all the PHO health promotion resource when there is so much need beyond this internal organisational development?

Feedback from limited circulation of a draft of this document has indicated some PHOs have already put considerable thought into the concept of health promoting ways of working for practices (under the concept of Health-Promoting Practices) as it differentiates from health promotion delivery in community settings, with current work to development frameworks and models of delivery. One way to share more about these activities would be to write about them and circulate as a response to this document.

Implementation realities of the Primary Care Strategy

The Primary Health Care Strategy paints a picture of community-centred holistic primary health care using 'Alma Ata' type language. This care would involve a wide variety of practitioners working cohesively as a team to serve their 'population'. However the reality of implementation of the Strategy is that the funding system of PHOs relies on the patient registers of general practice, and in 'mainstream' PHOs at present the majority of PHO services are delivered by those general practice teams². In relation to health promotion in PHOs, it can be suggested that PHOs need health promotion competencies rather than people specifically employed as health promoters per se. However given the different meanings attached to the words health promotion by those in PHOs, these would need to be health promotion competencies as understood by health promoters and public health people, not health promotion competencies as defined by the personal care use of the words. In many instances this would mean employing a health promoter as few nurses/doctors/pharmacists etc have health promotion competencies as defined by public health. This is particularly challenging in small PHOs where there is not enough health promotion funding to employ a separate health promoter even part time.

At present where health promoters are employed in PHOs, internal organisational development work in the PHO is likely to involve some interface with GPs and practice nurses. This interface can essentially be seen to operate at two levels, at the actual practice/provider level, and at the PHO level where for instance GPs and PNs may be in clinical advisory or workforce development roles, although there is obviously overlap as those in PHO level roles are likely to be practitioners in the PHO. I will lay out some thoughts about various activities that might be appropriate under each umbrella ('health promotion' and 'health-promoting ways of working') related to both levels. For many much of this may be very familiar territory but I would be interested in your thoughts about the perspective I have presented.

Interfacing with GPs and PNs at the practice level

While some may perceive general practitioners in private practice as focused on individual care and the maintenance of a viable business, the majority of those in general practice chose primary care as a vocation because of a genuine desire to make a difference in the lives of ordinary people. The privilege of sharing those lives in both the mundane, and the moments of deep significance such as terminal illness marks general practice as a site of unique interface with the community. Practice nurses (PNs) come with a different set of expectations and backgrounds from GPs, but again with a unique insight into the lives of the patients they see every day. **The question then is how we see health promotion in PHOs interfacing with, influencing and being influenced by, these doctors and nurses (and their important reception staff!). What do we really want and expect of them? How do we want them to interact with those leading health promotion work in their PHO?**

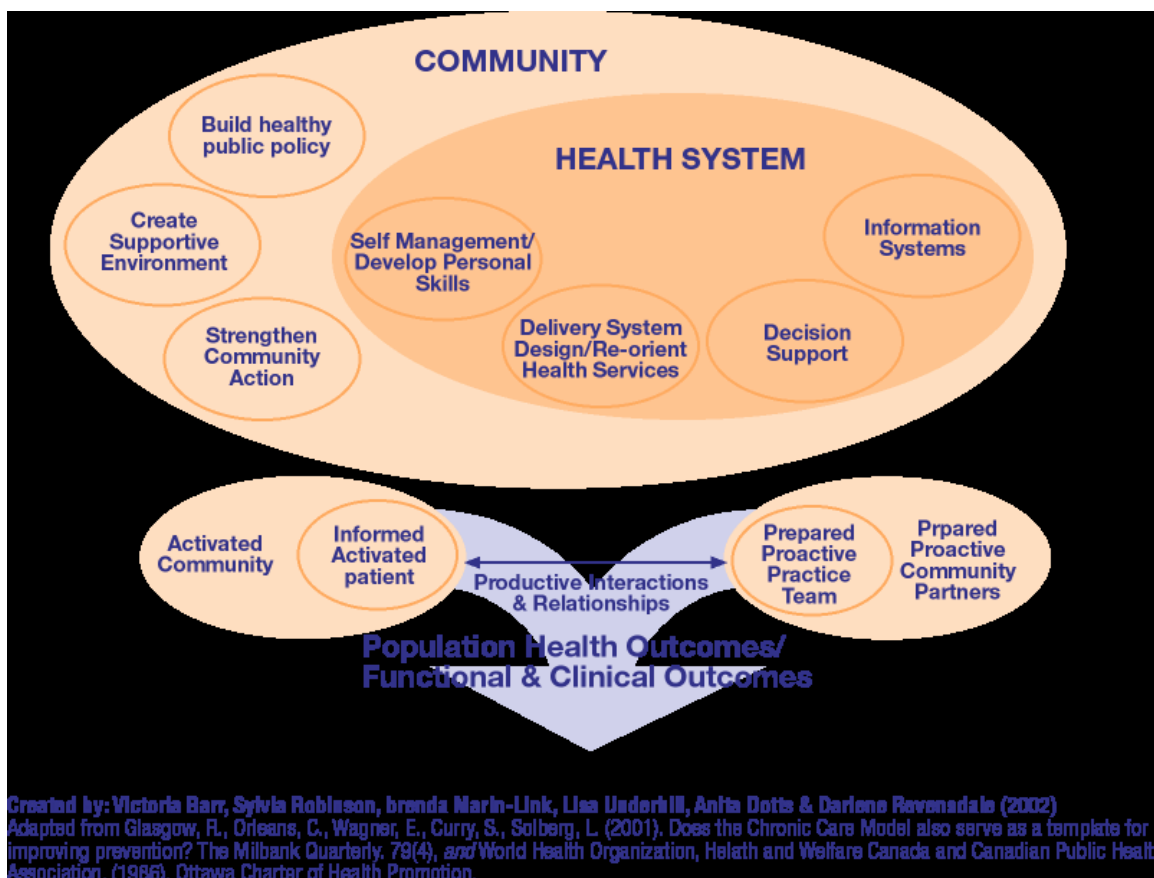
Some of these practitioners may be wanting to expand their world view or already be very aware of the need to address the broader determinants of health. They may be ready to consider how they might

² Community health workers and pharmacists are perhaps the two other groups most likely to be engaged by PHOs at present but for simplicity I have focused the discussion in this document on GPs and practice nurses.

support and be involved in advocacy efforts in their local community, or in fact already be doing so. For instance they may be involved in advocacy re housing and income, both for families and at community/agency level, participating in working groups or writing letters of support to change policies or conditions (eg refugee health action plan, supporting youth participation, contributing to action to reduce poverty, commenting on City council's policies or DHB priorities), and/ or supporting iwi aspirations. Others will be focused on trying to improve the quality of the clinical care they are trained to offer, believing that is the most valid contribution they can make to improving population health outcomes. Some may be overwhelmed by the huge clinical need already presenting to them every day, and have little energy or time to even consider how they might reorganise their practice under capitation to better deal with that need, let alone think beyond that. So what might health promotion in PHOs mean for each of these groups of primary care practitioners?

Chronic care opportunities

There is an increasing emphasis in general practice on chronic care, now supported by the Care Plus funding stream. Those GPs and PNs who with have read about or been involved in formal chronic care programmes will be familiar with Ed Wagner's Chronic Care model. This model identifies the essential elements of a health care system that encourage high-quality chronic disease care, including within the health system the design of service delivery, information systems, clinician decision support, and patient self-management support, and also acknowledging the importance of the community. The good news for health promotion in PHOs is that a group in British Columbia have adapted that model by adding three of the Ottawa Charter strands to expand what had previously been labelled 'Community Resources & Policies' (sorry I can't make the additions clearer by including the original model for comparison because of copy right restrictions). As in the diagram below, they have also attached personal skill development and reorientation of health services to factors they had already identified within the health system for chronic care (I will explore the relationship of personal skill development and self management from a health promotion perspective further below).



This means there is explicit recognition of the importance of the health promotion contribution to achieving population health outcomes in chronic care, and in particular in strengthening the functioning of both the health system, in this instance primary care, and the resources of the community. Many GPs and PNs are well aware that their health education efforts are futile if their patients have very limited life choices and are surrounded by an environment that makes the unhealthy choice the easy and most enticing choice. In their efforts to provide high quality clinical care they have been struggling to support such patients to improve their diabetic and/or cardiac status for many years with limited success.

The opportunity to work alongside someone who could facilitate better connections with some of the activities in the community that might support patients to make lasting changes in their own health, and then work to strengthen those community activities is likely to be welcomed by those GPs and PNs. While some may already be very involved in their community, and their efforts to do so need to be respected, to others it can be a welcome relief to have someone else on the team for these roles when they have plenty else to do clinically. So this type of work can be seen as 'health promotion', focused in the community, to be done by someone with health promotion expertise; however using the language of chronic care models can be a simple way of engaging GPs and PNs with that activity in a way that already makes sense in their world.

'Health-promoting ways of thinking' and systematic approaches to care

For those GPs and PNs who are buried under the avalanche of need, someone respectfully working alongside them, looking for systematic ways to link the need recognised in clinical consultations with community resources may stimulate those practitioners to consider other aspects of their care more systematically. Systematic approaches to care, and to documenting care, may be very familiar territory to some GP/PN teams. However for others it is talk they hear around them all the time, but the realities may seem just too hard in their situation. Encouraging them to think about how systems might be developed to target care to those with most need may help them streamline their workload, and can contribute to increasing capacity in primary care to reduce inequalities – part of the 'invisible work' of organisational capacity building³.

The importance of ethnicity in identifying those at risk of diabetes and cardiovascular disease is well recognised in general practice, but the concept of socio-economic deprivation/housing/social support being risk factors for major illness to note alongside ethnicity, family history, lifestyle habits, and the idea of recording these risk factors systematically is much less well established. So encouraging this type of inequalities thinking can be 'health promotion', undertaken by someone with health promotion expertise, but the actual doing of it will be a 'health-promoting way of working' by the GP team.

Consideration could also be given to how best to tap into some of the qualitative aspects of need that are detected daily by GPs and PNs in their interactions with patients, so that this information can be used shape PHO health promotion programmes. As a GP commented in a peer group discussion at the GP conference, these are 'unique insights into systems issues' that can complement those gained from the community in other ways. Some health promoters have found that 'popping in' to practices at lunchtimes and building informal links has helped to develop relationships where these kind of issues can be explored. Similarly having a regular 'catch up' slot in GP/PN cell groups can be a useful way to help GPs and PNs see health promotion as 'part of the team', working with them to improve outcomes⁴. Collating these insights together in a way that is useful for PHO health promotion planning could be seen as 'health promotion', part of the role of the person responsible for leading health promotion activity in the PHO, but would need to build on 'health-promoting ways of working' by GP teams so that the original information

³ Hawe, P., King, L., Noort, M., Gifford, S., & Lloyd, B. (1998). Working invisibly: health workers talk about capacity-building in health promotion. *Health Promotion International*, 13(4), 285 - 295.

⁴ These means of connecting may obviously be much more challenging in a rural environment where practices are widely dispersed geographically; it would be good to hear if people have experience of strategies that are effective in such situations.

gained in the consultation is captured in a meaningful and accessible way. To do this without creating another burden for GPs and PNs is a real challenge.

Self Management Education

Empowerment or capacity building is central to health promotion 'ways of working' and there are currently at least two streams of activity in clinical primary care where this way of working is already being advocated for by GPs and PNs themselves at a College and management level – Care Plus, and patient self-management education. Health promoters could consider how they might support and strengthen the drive to empowering 'ways of working' in these activities.

In presenting some Care Plus work at the GP conference, one GP bemoaned the fact that some practices reported they had found it 'more efficient' to fill out the patient self-management plan before the patient came! She recognised the importance of this plan reflecting the patient's goals and aspirations, not those of the GP or PN – in health promotion terms of the patient having increasing control over aspects of their health. Those driving the systems level organisation for patient self-management education recognise the importance of equipping people with skills to take this control, and the contribution this could make to reducing inequalities.

For those unfamiliar with current moves to self management education, Janine Bycroft, a New Zealand GP now training in public health is developing a website which will facilitate links to other key sites. For practitioners the Flinders model (Australia) has a strong focus on training practice staff, while the Lorig/Stanford model (from the US and used extensively in the UK) focuses on lay led self-management education groups. Essentially the models are based on consultation styles and lay led group activities to enhance problem solving and goal setting abilities, and self-efficacy – very much health-promoting ways of working.

Interfacing with GPs and PNs at the PHO level

This increasing attention being given to patient self-management education is likely to be driven at the PHO level, potentially with support from the DHB. At first glance it appears to fit well into the 'developing personal skills' strand of the Ottawa Charter. However as I understand it, the Bangkok Declaration reiterates the intention of this strand to reflect developing skills to influence the wider collective determinants of health, rather than individuals learning skills to better control aspects of their own health, which is the thrust of self-management education. Thus in the Auckland region we have suggested this work be funded under streams such as SIA and health promotion funding reserved for the collective community activities that might support such work (the use of SIA also gives the PHO an onus to focus the self-management work on those who are demographically high need – Māori/Pacific/Quintile 5 – rather than just clinically high need).

However, given the current lack of other funding streams for self-management education where this is not focused on demographic high needs patients, and the potential for those who have developed increased self-efficacy to be nurtured into opportunities for community leadership, this question of which funding stream is appropriate is likely to be an area with which we will all continue to have to grapple. Certainly though, the push for self-management education is one which would seem logical for health promotion to support, as reflecting a health-promoting way of improving outcomes in chronic care.

It also highlights the potential for much better integration of health promotion activities with those funded by SIA funding. Similarly, an important way to support health-promoting ways of working by the PHO would be to feedback to the PHO learnings from health promotion programmes about the needs and access barriers (beyond simply the financial ones) of Maori/Pacific/Quintile 5 populations, so as to better target SIA activities. This would be work for the designated health promoter but does raise the issue of how health promoters in PHOs might best interact with their PHO Boards, some of whom are likely to be GPs and/or PNs, to support health-promoting approaches to PHO decision making. PHO Boards are usually very pressured for time, and unlikely in my experience to want to commit any significant chunk of time to a theoretical look at health promotion/public health. However I suspect they may be interested in a

1 hour 'How to evaluate a Health Promotion Plan presented for Board sign off' session that equips them with practical skills to better do their job, while exposing them to what might be considered good practice in health promotion. This could be also be used as a platform for discussing with the Board the integration of health promotion planning with SIA planning⁵.

Summary

The concept that in the current world of health promotion in PHOs it may be useful to differentiate between 'health promotion', to be planned and undertaken by a skilled health promotion workforce, and 'health-promoting ways of working' by all in the PHO, to be facilitated/encouraged, recognised/validated by health promoters has been explored. Various activities that might be appropriate under each umbrella have been discussed. It is suggested this differentiation may help to hold in balance the tension between wanting to better validate and recognise health promotion as having a unique contribution to make in its own right, and wanting to encourage all those in the world of primary care to be increasingly 'health-promoting' in their ways of thinking and working. It may also be useful going forward in differentiating activities that are appropriate to be funded by the PHO health promotion funding stream and those that should utilise other funding, so that PHO activities are integrated but health promotion funding is not swallowed up by individually focused activities.

As I have begun to discuss these ideas with others, it has been suggested this differentiation between 'health promotion' and 'health promoting ways of working' might be useful in health promotion work beyond the PHO, at different levels in the community and other institutions.

Your thoughts please!

⁵ I would be keen to coordinate some collective input into how such a session might look if others are interested.