# Health promotion in PHOs:

## Towards a mutual understanding of this new resource in the primary care team

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ABSTRACT

The vast majority of general practice teams in New Zealand are now part of a local Primary Health Organisation (PHO). PHO funding includes a small amount of public health revenue channelled through PHOs for health promotion activities. Expectations for the use of this funding depend on understandings of the term 'health promotion'. Those in general practice teams are likely to have health promotion understandings related to individual or whanau-focused clinical preventive and health education activities. Public health understandings of health promotion relate to collective activities to build community capacity and strengthen alliances between health and non-health providers to influence societal systems and structures that affect health. The integration of this broader community-based approach to health promotion alongside the clinical activity of primary care teams has the potential to strengthen the contribution of general practice to improving population health outcomes.

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### Introduction

The vast majority of general practice teams in New Zealand are now part of a local Primary Health Organisation (PHO). The complex implementation realities of this latest restructure of primary care organisation are acknowledged but not further debated here. However, along with other funding changes, the formation of PHOs has included a small amount of public health revenue being channelled through these organisations in the form of a health promotion funding stream. This funding is small relative to other sources of PHO revenue, frequently only amounting to 1–2% of the total PHO revenue even in high needs areas, but is significant relative to other public health discretionary health promotion budgets.

In the future, overall responsibility for this funding stream is likely to be devolved to DHBs. However, at present, while other PHO funding streams are under the jurisdiction of the Clinical Services Directorate at the Ministry of Health, the Health Promotion funding stream sits under the Public Health Directorate. This means expectations for use of this funding are related to public health understandings of the term 'health promotion'. However in many instances these expectations are being realised in the context of PHOs built on a foundation of mainstream general practice teams. These general practice teams may have different understandings and subsequent expectations of the use of such funding.

This article seeks to promote shared understanding of this new resource and its potential contribution as part of the primary care team to strengthening the work of general practice.

### Primary care understandings of the term 'health promotion'

A scan of primary care literature suggests that understandings of 'health promotion' in general practice largely relate to clinical preventive activity and health education in the setting of individual and/or whanau consultations. A recent College publication on preventive care and screening delineates health promotion as 'lifestyle advice/education'.[1] The RNZCGP curriculum for the vocational education of general practitioners, published in 1998 and currently being reviewed, refers to an increasing emphasis on health promotion and the prevention of illness as being one of the changes with which New Zealand general practice has been confronted.[2] Health promo-

tion is referred to a number of times in the curriculum, although not defined. These references relate health promotion to health education, immunisation and screening in the context of patient consultations. The curriculum does contain some reference to broader conceptualisations of health promotion, in relation to meeting the needs of Maori (vol. 7) and environmental health (vol. 9).

The College quality measurement tool, *Aiming for Excellence*, which is key to the Cornerstone accreditation process, also uses the term health promotion. This use is in the title of a group of indicators referring largely to practice systems related to screening and guideline implementation, but also to the provision of *'health promotion activity...and material'* in the context of *'educational information on health improvement, illness and disability prevention'*.[3]

Wider scanning of primary care literature using the term 'health promotion', for instance using an online search of an electronic journal such as *Family Practice*, finds statements such as *'health promotion is an established part of the GP consultation'*.* There are articles describing health promotion clinics, general practice-based health promotion activities (offering health checks), health promotion messages (waiting room posters), and health promotion advice. In discussing the latter, mention is made of the recognition that 'health promotion' involves more than simple information and advice, and the need for increased skills in lifestyle counselling.†

Nursing literature recognises a variety of conceptions of the term 'health promotion', usually in the context of self care and health education, but with an emphasis on client-centredness and empowerment.[4] Certainly there is a belief that many nursing activities in primary care are 'promoting health'.[5]

While having some common threads about people making changes to influence their well-being, these understandings stand somewhat in contrast to the understanding of 'health promotion' for someone trained as a health promoter.

## Health promoters' understandings of the term 'health promotion'

In Aotearoa New Zealand from the 1990s onwards, the understanding of 'health promotion' for those formally trained as health promoters has been about activity focused on building community capacity and influencing societal systems and structures.[6-11] It emphasises:

(a) collective action and collaboration
(b) intersectoral approaches – determining what the health sector can do and where there is need to influence other sectors (e.g. housing, education, employment), with a perspective that largely health is restored in the health sector but created in other sectors
(c) a concern for socio-economic determinants of health and equity of outcomes
(d) a significant emphasis on the Treaty of Waitangi, and acknowledging Maori models of health and practice‡
(e) assisting people/communities to make sustainable changes towards health by empowering and enabling them – the idea that people having a sense of influence and control over the things that determine their well-being is important.

In the past, health promoters who work with these understandings have pulled back from working alongside clinical teams to get traction for their wider approaches, feeling that their priorities were otherwise at risk of being overwhelmed by all the obvious clinical needs.[12] Had the funding currently channelled as 'Health Promotion' in PHOs been contracted through other public health processes and not specifically associated with PHOs, this separation of activity could have been maintained. However, given that, instead, this new funding has been put alongside clinical practice in PHOs, there is now a significant challenge for all those involved: health promoters to try to work out how they can add value to what clinical teams are doing without losing their own ways of thinking and working, and clinical teams to understand what all this is about and how it relates to them.

## Health promotion in PHOs – moving to shared understandings

Previous reviews of the interface of public health and primary care have often emphasised the differences in the 'world-views' of those on either side.[13,14] However it is the author's 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 a dichotomy of paradigms. For instance, as part of a consultation process in the wider Auckland region related to workforce development for health promotion in PHOs, people from a variety of backgrounds, including general practice doctors and nurses, health service managers, public health physicians and health promoters ,have grappled together with questions such as:

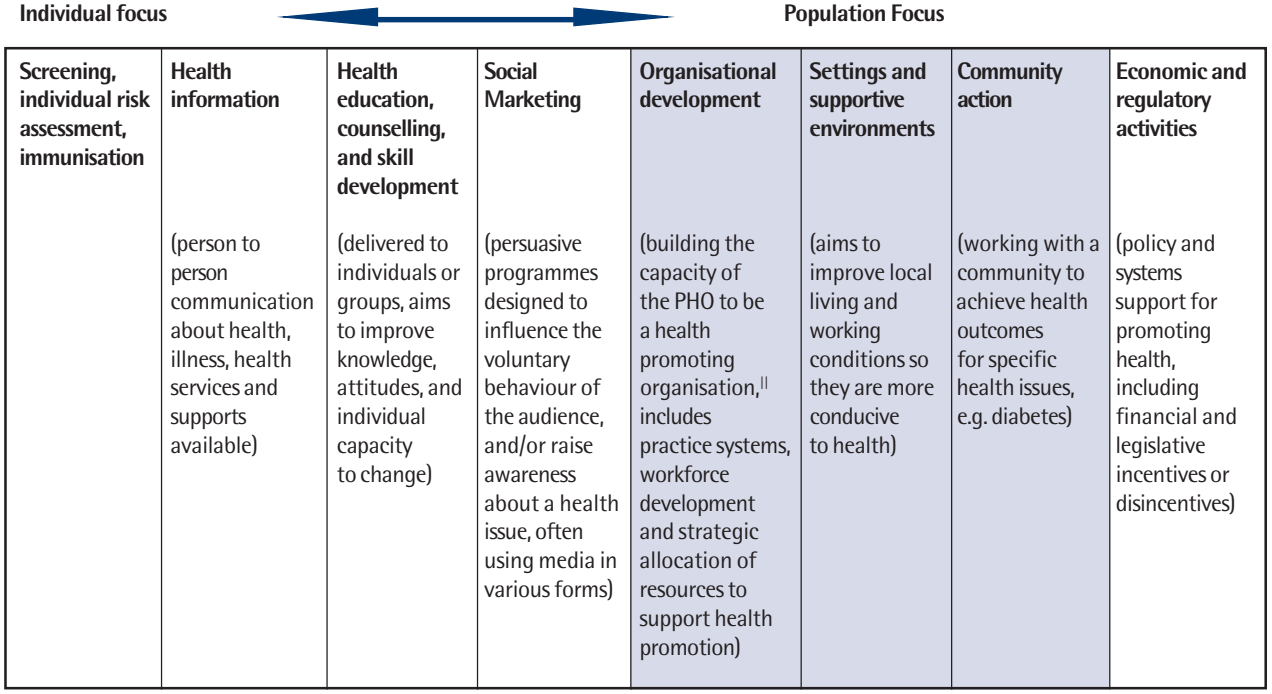
(a) What does health promotion actually look like in a PHO – is it about health education and preventive activities, or tackling wider envi-

* Richards H, Reida M and Wattb G. Victim-blaming revisited: a qualitative study of beliefs about illness causation, and responses to chest pain. Family Practice 2003; 20(6):711–716.

† Steptoe A, et al. Attitudes to cardiovascular health promotion among GPs and practice nurses. Family Practice 1999; 16:158–163.

‡ This includes the formulation in 2002 of TUHA–NZ (A Treaty Understanding of Hauora in Aotearoa–New Zealand) which looks at what Treaty-based practice means in everyday health promotion work.

*Figure 1. The range of potential activities which could be adopted by PHOs to address population issues*




*(Adapted from Ministry of Health, New Zealand[6] and Department of Human Services, Victoria State Government[17])*

ronmental/structural concerns, both social and physical?

(b) If it is about wider collective activities, is it just about programmes such as physical activity programmes in the community (noting that to be 'health-promoting' these also need to include community capacity building), or does it include reorientation of health services, and building healthy public policy as per the Ottawa Charter?

(c) For management people who are expected to report on what they've achieved with this funding stream, what outcomes are expected and how are they to be evaluated, given the long-term nature of many health promotion goals?

(d) And how does all that fit with the concept of population health?

There was a recognition in this consultation process that initiatives related to health promotion and population health in primary care need to be built on a strengths-based approach, acknowledging the strengths and activities of primary care as well as public health.[8,15] At a time when health promotion as a profession is seeking to be better validated and recognised as having a unique contribution to make in its own right (McGregor cited in Winnard[16]), health promoters working in PHOs are needing to value and validate all the efforts and backgrounds people bring to a wider picture of health-promoting activity in the primary care setting.

A subsequent facilitated process in the wider Auckland region, in which the author took a co-lead role, has developed guidelines for health promotion activity in PHOs in the region. These guidelines are based on, and attempt to be more explicit than, the previous limited guidance provided to date from the Ministry of Health.[6,§] They are focused around the recognition of a spectrum of population health activity (see Figure 1). This spectrum highlights the importance of the integration of a variety of approaches to achieve population health goals, involving both those with an individual and a population focus.

In this spectrum 'health promotion consultations', as understood by GPs and practice nurses, fit towards the left as important clinical activities which could be complemented by activities by a PHO health promoter as outlined in the shaded boxes: organisational

§ At a recent national hui, the Auckland regional guidelines were noted as having potential usefulness for other regions, but as yet there has not been any coordinated work to advance this suggestion. However, they stand as an example of current understanding about health promotion in PHOs from those involved in this work in at least one area.

|| ...by ensuring policies, priorities and practices apply health promotion principles.

development, supportive environments, community action. However, for the sake of clarity about the use of the health promotion funding stream in PHOs, the individually focused activities at the left of the spectrum are not labelled 'health promotion'.

### The potential of health promotion as part of the PHO team

Many GPs and practice nurses are well aware that their health education efforts can be futile if their patients have very limited life choices and are surrounded by an environment that makes the unhealthy choice the easiest and most enticing one. In their efforts to provide high quality clinical care, they may have been struggling to support such patients to improve their diabetic and/or cardiac status for many years with limited success. Some GPs and practice nurses may already be involved in advocacy efforts in their local community to influence broader factors that affect the health of their patients. For others, knowing there is someone else in the PHO team who can 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 be working to strengthen those community activities, may be a welcome relief when, as clinicians, they have plenty else demanding their time and energy. Many NGOs (non-government organisations) are also seeking ways to strengthen their relationships with primary care, and health promotion resources in a PHO have the capacity to help facilitate this.

This potential for health promotion in PHOs to contribute to strengthening the functioning of both the health system, in this instance primary care, and the resources of the community, can be demonstrated by consideration of chronic care. Those GPs and practice nurses who 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 encourages high-quality chronic disease care and includes:

(i) the design of service delivery
(ii) information systems
(iii) clinician decision support, and
(iv) patient self-management support

..and beyond the health system also acknowledges the importance of the community.[18]

The Ottawa Charter is a foundational health promotion document frequently used in health promotion planning, which highlights five streams of potential health promotion activity:

(i) building healthy public policy
(ii) creating supportive environments
(iii) strengthening community action
(iv) developing personal skills, and
(v) reorienting health services.[19]

Recently a group in British Columbia has adapted the Chronic Care Model by adding three of the Ottawa Charter strands to expand what had previously been labelled *'Community Resources and Policies'*.¶ They have also attached the Ottawa Charter strands of personal skill development and reorientation of health services to factors that had already been identified as important within the health system for chronic care.**

This adapted model (Figure 2) can be applied to the prevention of chronic disease as well as its treatment[18] and makes explicit the role of wider community-based health promotion activities alongside the clinical activities of the primary care team. For example, such an approach to smokefree would emphasise the importance of systematic approaches to addressing tobacco use with patients, recording such interactions, ensuring all clinical staff are equipped to provide brief interventions to encourage quit behaviour, effective links to community organisations providing quit support, and advocacy and support of community initiatives to promote smokefree environments.

This model also highlights the potential for better integration of health promotion activities with those funded by other PHO funding streams. The privilege of sharing the lives of patients and their families/whanau 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. Consideration could be given to how best to tap into some of the qualitative aspects of need that are detected daily by GPs and practice nurses in these interactions, so that this information can be used to shape PHO health promotion programmes. As a GP commented in a peer group discussion at the College conference, these are 'unique insights into systems issues' that can complement those gained from the community in other ways.

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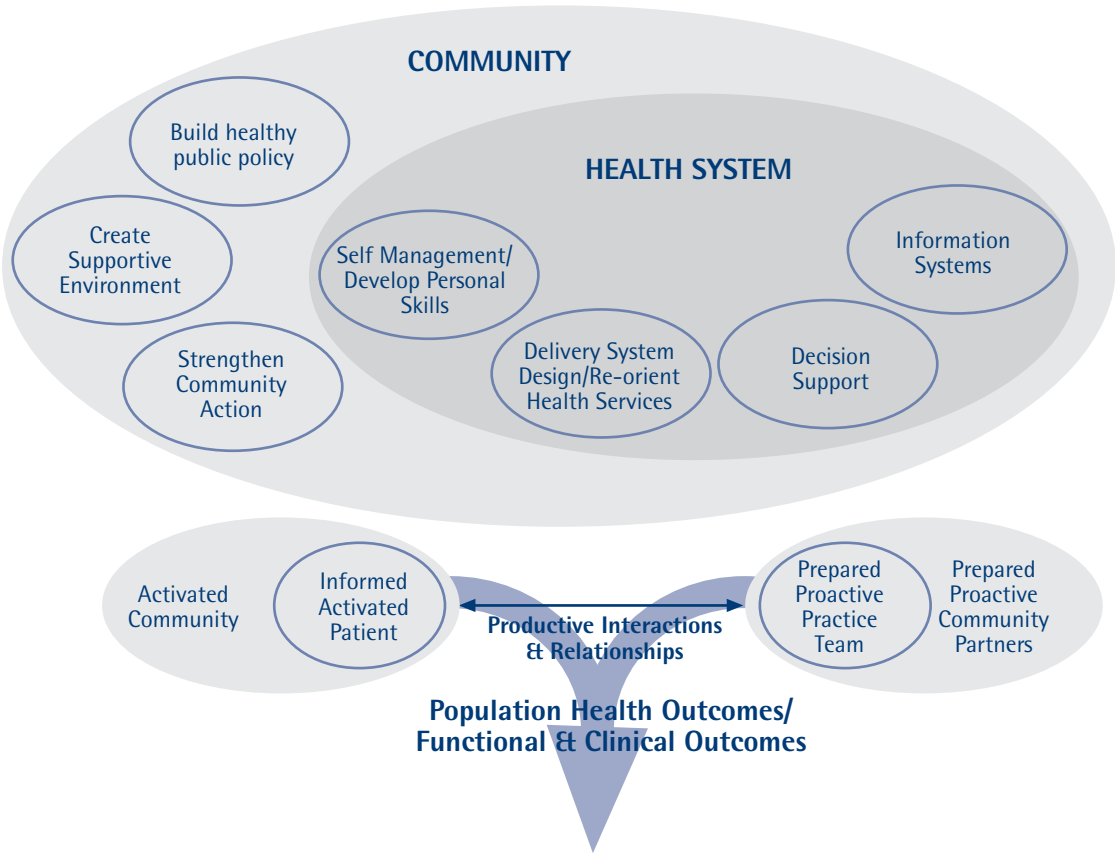
¶ I am unable to make the additions clearer by including the original model for comparison because of copyright restrictions.

** At first glance, the increasing attention being given to patient self-management education looks to fit into the 'developing personal skills' strand of the Ottawa Charter. However, the more recent declaration from the international Bangkok Health Promotion Conference 2005 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, it is suggested this work be funded under streams such as SIA, while health promotion funding is reserved for the collective community activities that might support such work. There is of course potential for those who have developed increased self-efficacy through self-management education programmes to be nurtured into opportunities for community leadership, highlighting the importance of linking such programmes to health promotion activities to fully capitalise on potential benefits. Certainly the push for self-management education is one which a health promoter would support, as reflecting a 'health-promoting way of working'.

*Figure 2. Adapted Chronic Care Model*




*Created by: Victoria Barr, Sylvia Robinson, Brenda Marin-Link, Lisa Underhill, Anita Dotts & Darlene Ravensdale (2002) Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solberg, L. (2001). Does the Chronic Care Model also serve as a template for improving prevention? The Milbank Quarterly, 79(4), and World Health Organization, Health and Welfare Canada and Canadian Public Health Association. (1986). Ottawa Charter of Health Promotion.*

Similarly, learning from health promotion programmes about the needs and access barriers of demographic high needs populations (most commonly Maori/Pacific/Quintile 5 populations), beyond simply the financial ones, can be fed back to the PHO so as to better target activities such as SIA programmes.

The College has recently affirmed its belief that the focus of primary care should now be on reducing disparity in health outcomes.[20] Health promotion thinking would suggest that socio-economic deprivation/housing/social support are risk factors for major illness that could be systematically recorded alongside ethnicity, family history, lifestyle habits so that practices are better equipped to decrease health inequalities and improve health outcomes. This is important in relation to preventive and screening activity such as offering health checks, as even when well promoted, untargeted this activity has been demonstrated to have greater uptake by more affluent patients[21] thus potentially increasingly inequalities.

## In summary

If we understand health promotion to mean a set of activities that are part of a wider spectrum of population health activities in a PHO that complement clinical activity, the potential of PHOs is well reflected in a quote from Angell: *'dealing with the social causes of disease and responding to its medical effects are not mutually exclusive. We should do both'*.[22]

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## Competing interests

None declared.

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*Strengthening the links and improving communication between GPs and specialist physicians can only benefit both groups - and ultimately the patients we share. It is good to see the college at the forefront of this movement, and our flagship journal leading the charge!'*

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*FridayFax, the weekly newsletter of the The Royal Australian College of General Practitioners, 15 December 2006. Accessed 29 January 2007. http://www.racgp.org.au/fridayfax; mailto:friday.fax@racgp.org.au*