

## **Building capacity to deliver better health promotion programs**

Evidence indicates that health-promoting interventions that rely solely on changing individual behaviour by reducing exposure to risk factors are the least effective in terms of reducing health inequalities and therefore of improving health differentials at the population level.<sup>1</sup>

Given this evidence each Primary Care Partnership (PCP) has been funded specifically to lead and develop a more integrated approach to health promotion as part of their Community Health Plans. They are focusing on implementing a *mix* of health promotion interventions that influence public policy, facilitate action across different sectors and improve personal skills, *balanced* with underpinning core strategies that build community and primary health agencies' capacity to improve health outcomes.

### **So what has happened?**

#### **An example from Upper Hume Primary Care Partnership**

**The Upper Hume PCP** (UHPCP) has worked with their member agencies to develop a formal approach to build their capacity to work together on health promotion. A Health Promotion Capacity Review was conducted to identify the agencies and staff with health promotion skills and capacity. The PCP is now coordinating the development of a shared work plan as the basis of a framework for future planning, implementation and evaluation of health promotion. This founding capacity work has provided a sound base for the ongoing coordination and delivery of programs to address key population health and well-being needs in the Upper Hume catchment area.

### **So what has Health Promotion Capacity Review revealed?**

. The review was composed of three domains: the community, management & governance and practitioners. Eighteen participating members undertook the review to identify health promotion strengths and best practice within the UHPCP.

Analysis of the results has identified these best practice pointers:

**Effective consumer participation** requires agencies to support and train consumer representative groups to participate in all levels of agency planning, including corporate service, and program planning. There are differing levels of consumer participation needed including:

- Having consumers and nominated consumer advocates on quality management teams
- The development of community advisory or liaison groups
- Having consumers and nominated consumer advocates providing input into policy development.

Agencies also need the flexibility to be able to respond to individuals and groups, as well as demonstrating that they understand their community of interest.

Health promotion activities should be informed **by local socio-demographic and health profiles, community priorities, and quality & effectiveness evidence based interventions**. Exemplary practice requires **linking** these needs assessment process with **local service & corporate planning processes**.

**Workplaces that are health promoting** require a whole of organisation approach, where the overall culture of the organisation reflects **community development principles**. Organisations with this type of culture have:

- Flat management structures.
- Financial and management delegations.
- Devolved and shared decision making around resource allocation.
- Flexible work practices (flexible working hours, the ability to work from home, flexible use of leave, and flexible policies relating to family and children at work)
- Staff health programs and family-friendly environments.
- Support for staff to access professional development opportunities such as relevant courses and conferences, mentoring opportunities, the Internet, libraries and subscriptions to primary health care/health promotion journals.
- High levels of staff satisfaction, where staff feel they are acknowledged for their **leadership and innovation**.
- staff giving and being provided with feedback at meetings.

The **Systems** which need to be in place to support service and organisational commitment to health promotion including:

- Inter and intra agency networks.
- Health promotion committees.
- Corporate and service plans.
- Policies and procedures that enable consistent, quality health promotion reporting and incorporation of recommendations.
- Positions dedicated to health promotion coordination.
- Consumer advocacy, and community participation strategies.

**Health promotion intersectoral and interagency alliances are highly valued and recognised as being fundamental** for purposes of planning, service coordination, case management and care coordination. Significant resourcing of networks and backfill of staff (where possible) is required to allow such intersectoral and interagency alliances to function.

**Commitment to health promotion values and practice by senior management & board members** needs to be demonstrated through:

- Their participation on Health promotion committees and projects.
- Senior managers providing leadership with regard to community development and consumer participation strategies
- Board business papers and agenda's including health promotion and community development issues

- Board/management support for the allocation of resources to health promoting activities.

For executive positions to have health promotion accountability **appropriate performance indicators for executive staff relating to health promotion** and community development need to be developed and implemented. Similarly for positions at all levels to have health promotion responsibility, health promoting values and specific actions should be included in position descriptions.

**Appropriate allocation of health promotion funds** requires health promotion responsibility being built into the role of many existing programs, coupled with specifically allocated health promotion resources to dedicated positions. These dedicated position provide expertise and coordinate health promotion initiatives. Resourcefulness in resource allocation also requires skilling staff to have a basic knowledge concerning the allocation of resources and how decisions relating to resource allocations are made within their organisations.

Program funding and reporting requirements must also acknowledge **both the population approach and cost effectiveness of health promoting activities** and not be focussed just on acquittals against client contacts, at the treatment or secondary prevention end of the service continuum. Flexibility in funding and reporting guidelines is also required to allow the incorporation of health promotion action into everyday practice.

**The review highlighted that working through the primary care partnership structure significantly enhanced intersectoral and interagency collaboration. The majority of partner members saw the PCP arrangements as a significant support system in itself.**

The purpose of the review was to identify the organisational development priorities for the UHPCP. The process:

- Rewarded agencies for their existing levels of capacity.
- Allowed the PCP member agencies to work together to identify those areas requiring development to ensure quality service delivery.

See a complete version of the Health Promotion Capacity Review *Report* to see the **future recommendations for action**.

The Health Promotion Capacity Review was prepared by Mary Hoodless, Frank Evans and Kerry Flanagan (Rural Health Innovations for the Upper Hume PCP).

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<sup>1</sup> Turrel G., Oldenburg B., McGuffog I., Dent R., (1999) *Socioeconomic determinants of health: towards a national research program and a policy and intervention agenda*, Queensland University of Technology, School of Public Health, Ausinfo, Canberra.