Roles, job market, and evidence into practice of health education professionals in the UK

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Abstract

This paper reviews the position of health promotion in England and, in particular, how structural change and reorganisation within the NHS, along with the emergence of multi-disciplinary public health, have been a challenge to its identity. It draws lessons from recent experience to emphasise the distinctive contribution of health promotion to public health and the need for proper recognition and career progression for health promotion staff. It argues that the specification of competences should be informed by a health promotion discourse and that as well as defining skills these should also include the values and ethical principles of health promotion. It argues that practice should be evidence-based and health practitioners have a responsibility to draw critically on evidence and also to generate the type of evaluation evidence which would inform dissemination.

Introduction

This paper will look at the position of health promotion in the UK. Because there are some differences between the four countries which make up the UK (England, Wales, Scotland and Northern Ireland), for simplicity, it will focus on the position in England. Health Promotion started out strongly in the 1980s, but has recently been through a difficult period. Its early position will therefore be described before considering the recent changes which led to its demise. It is now emerging from this unsettled period and the prospects are considerably more optimistic. The current position will be outlined and, given its central importance, the implications for evidence-based practice. Finally the lessons learned from recent experiences of the delivery of health promotion will be summarised.

Historical roots

If we were to turn the clock back some 20 years or so, it would be very much easier to summarise the position of health promotion in England. At that time Health Promotion Departments or Units existed in each Area Health Authority of the National Health Service (NHS) which broadly covered the same geographic areas as Local Government. In the late 1980's the name health promotion was preferred to health education and many Departments which had formerly been known as Health Education Units changed their name accordingly. This was in response to:

- critiques of health education's emphasis on individual behaviour which was associated with 'victim-blaming'

- increasing recognition of the need to address upstream determinants – the so-called 'causes of the causes'
- a shift in emphasis from individual behaviour to creating supportive environments for health through healthy public policy.

These Health Promotion Departments/Units were staffed by individuals from a range of professional backgrounds who were known initially as Health Promotion Officers and later as Health Promotion Specialists to reflect their specific focus on this area of work. Although many possessed post-graduate qualifications in health promotion, this was not essential. Similarly there was no formal regulation or registration – indeed there was considerable resistance to introducing such control on the grounds that it would be elitist and unnecessarily restrictive.

Outside the NHS there were others whose work was wholly engaged in health promotion as opposed to those for whom health promotion constituted a small proportion of their work. These health promotion workers were located in Local Government and NGOs.

At national level, programmes and resources were developed and training and support provided for those working locally. From 1968-87 a national body, the Health Education Council – a QUANGO, took on this role. This was replaced in 1987 by the Health Education Authority which was responsible directly to government. In 2000 this became the Health Development Agency which switched the emphasis to focus particularly on building an evidence base for health promotion and tackling health inequality. In 2005 the Health Development Agency was assimilated into the National Institute for Clinical Excellence (NICE).

In terms of professional advocacy there was the Society for Health Education and Promotion Specialists. There were also numerous national and regional networks such as Health for All networks and Healthy City networks.

An important issue was the relationship between health promotion and public health medicine. Health promotion, which subscribed to a social model of health sought to maintain a separate identity and distance itself from public health medicine which was associated with a preventive medical model.

A period of turbulence and change

During the 1990s and early 21st century the position of health promotion was significantly affected by a series of changes which included:

- structural change and repeated re-organisation within the NHS
- political change
- the emergence of multi-disciplinary public health

The introduction of the NHS internal market in the early 1990s devolved much decision-making to the local level. It effectively split the NHS into a commissioning arm responsible for assessing local need and commissioning services to meet this and a provider arm which delivers services. The role of health promotion staff which encompasses needs assessment and strategic planning as well as the operational delivery of programmes has never fitted easily with this structure. This has led to fragmentation of health promotion services and in some areas loss of a critical mass of health promotion expertise.

Responsibility for commissioning services currently rests with Primary Care Trusts (PCTs). Following the latest reorganisation there are 152 PCTs in England serving the population of approximately 50 million. Public health tends to have a prominent role in commissioning. However, there is considerable variation across the country in how health promotion and public health services are organised and their position with regard to the purchaser/provider split. In some areas the position of health promotion appears to be strong, particularly where there is recognition among commissioners of the important contribution specialist health promotion staff can make to achieving targets for improving the public's health. In other areas health promotion posts have been lost or re-designated (White, 2008). A recent report by the Audit Commission (2008) noted that:

> Continuous reorganisation created uncertainty for managers, staff and partner organisations. In addition, critical functions such as health promotion were lost in reorganisations and the redesign of local healthcare organisations. (p74)

Further:

> .... concerns remain that here are few immediate or long term plans to train a workforce to deliver across agencies, work with communities and deliver health promotion. (p74)

In many ways the policy climate has never before been so supportive of health promotion with its emphasis on improving health and tackling health inequalities. Yet at the same time there has been a failure to recognise the specific contribution of health promotion to improving the health and well-being of the population. Equally many of the priorities of health promotion including tackling inequality and social exclusion, involving local communities and building partnerships between sectors have been mainstreamed and taken on by a range of different organisations effectively marginalising health promotion.

A major issue has been the emergence of multi-disciplinary public health within which health promotion has been assimilated. The term health promotion began to be used less frequently in government policy documents, job titles and university course titles – to be replaced by terms such as health development, health improvement and indeed public health.

The origins of modern multi-disciplinary public health in England can be traced back to the Acheson Report (Department of Health, 1988) which defined public health as:

> … the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society.

The report also recognized that public health

> … works through partnerships that cut across disciplinary, professional and organizational boundaries and exploits this diversity in collaboration, to bring evidence and research based policies to all areas which impact on the health and well being of populations.

This wider view of public health was welcome in that it recognised the contribution to health of a wide range of professionals and sectors rather than it being restricted to public health medicine and the sole province of the medical profession. It also opened up senior public health posts such as Director of Public Health to those who were not medically qualified. This created more career opportunities for those working in health promotion which had formerly had a very flat career structure. At the same time it resulted in some of the most senior staff moving out of health promotion and into public health.

Three main groups of public health workers were identified in The English CMO's Project to Strengthen the Public Health Function (Department of Health 2001):

> 1. Wider public health workforce: those who make a positive contribution to public health through their work although their primary role may not necessarily be public health for example teachers, social workers;
>
> 2. Public health practitioners: those who spend a major part of their time involved in public health practice for example health visitors, environmental health officers;
>
> 3. Public health specialists: those who work at a strategic or senior level.

Clearly health promotion is an integral part of public health and its range of activity bridges categories 2 and 3 above. The Bangkok Charter (WHO, 2005) refers to health promotion as a 'core function of public health'. Potvin and McQueen describe health promotion as 'a strategy for public health that reflects modernity' (2007: 14).

What has been the effect of assimilating health promotion under the multi-disciplinary public health umbrella? For some it has been viewed positively in that it recognises the contribution of a range of different workers to public health. Others – and particularly those working in health promotion – have been concerned that it reduces health promotion to a series of functions within public health and that this undermines it as a discipline and profession and, importantly, its ideological basis. The consequences can be summarised as:

- Loss of professional identity for those working in health promotion
- Uncertainty among health promotion staff about their role and future
- No lead national agency for health promotion
- The term health promotion used less frequently
- Dominance of a public health rather than a health promotion discourse

The key question is 'does this matter?' Most of those who claim to be 'health promoters' would see commonalities with the broad statement of purpose used for public health:

- to improve health and wellbeing in the population
- to prevent disease and minimise its consequences
- to prolong valued life
- to reduce inequalities in health.

(Skills for Health, 2009:4)

However it is important to recognise the specific contribution which health promotion makes and maintain its identity as a discipline with its own ideology and theoretical base. A study in the UK by Tilford et al (2003) concluded that within the context of the move to multidisciplinary public health, health promotion makes a distinctive contribution through its core values - both terminal values or goals and instrumental values associated with the means of achieving goals. Terminal values include a holistic conceptualisation of health, equity, empowerment, autonomy/self determination and justice/fairness. Although there was some consensus between the values of public health and health promotion there was a much stronger emphasis for health promotion on empowerment and autonomy and greater attention to ways of working and the means of achieving goals in line with the instrumental values of involvement and participation.

A report on the future of health promotion (Griffiths and Dark, 2005: 6) found that specialised health promotion has 'been eroded in recent years due to repeated organisational change, and lack of focused and proactive advocacy and development'.

The report emphasised that while health promotion is part of multi-disciplinary public health it should be recognised as a discipline in its own right. Health promotion staff have specific competences which are essential for achieving public health goals. These were identified by the report as:

- Ensuring that the implementation of public health interventions is evidence based
- Building capacity for health promotion

And more specifically:

- Helping people to make and maintain informed health choices – by providing information, resources, training and support to the wider public health workforce (and also by directly offering health information, motivation and support to people)
- Empowering and mobilising local communities for health - including the optimal use of different settings for health promotion (schools, the workplace etc.)
- Developing health programmes and services, especially to reduce inequalities in health - drawing on the theoretical models and principles of effective health promotion practice. (p26)

It recommended that the specialist health promotion workforce requires recognition and advocacy along with systematic skills and competency development. A collaborative programme 'Shaping the Future of Health Promotion' was set up in 2006 to implement these recommendations and

- achieve recognition and identity for specialised health promotion
- develop an agreed career pathway for specialised health promotion staff.

The Future - Towards a competent health promotion workforce

The Shaping the Future Report (Griffiths and Dark, 2005) estimated there to be about 2000FTE health promotion staff in the NHS in England and Wales. The way specialist health promotion services were structured and organised varied considerably between different areas. For example at that time there were around 300 PCTs and numbers of specialist health promotion staff were as follows:

in 53 PCTs <5 specialised health promotion staff
in 69 PCTs 5 – 9 specialised health promotion staff
in 54 PCTs 10 – 19 specialised health promotion staff
in 26 PCTs >20 specialised health promotion staff
Rather than have their own separate service, 104 PCTs linked with other PCTs to provide a health promotion service - creating 36 joint services.

Roles and responsibilities also vary – some staff working on vertical programmes such as coronary heart disease or smoking cessation, others working on different settings such as health schools or healthy cities, some involved in community development work. The Shaping the Future Collaboration (see < http://www.rsph.org.uk/en/health-promotion/>) has been an advocate at both national and local levels for the contribution of specialist health promotion staff to achieving national and local health targets and the need to maintain a critical mass of staff.

A statement on priorities for action issued by the International Union for Health Promotion and Education (IUHPE) and the Canadian Consortium for Health Promotion Research (also, and coincidentally, called *Shaping the Future*) identified a specialist health promotion role as well as the need for a multisectoral response. It emphasised the importance of building a competent health promotion workforce. In England, although there was some attempt to define competences for health promotion (Care Sector Consortium, 1997), latterly, the specification of competences has been shaped by the public health skills and career framework. This incorporates the whole of the multi-disciplinary public health workforce from initial entry through to the most senior levels (Skills for Health, 2009). The framework identifies a number of core competences operationalised for nine levels of seniority as well as five defined areas of competence. The core areas define competences which everyone working in public health should have. In contrast, the defined areas apply to those working in particular fields. Different professional groups will have their own standards, competences and training.

Core areas

1.Surveillance and assessment of the population's health and wellbeing

2. Assessing the evidence of effectiveness of interventions, programmes and services to improve population health and wellbeing

3. Policy and strategy development and implementation for population health and wellbeing

4. Leadership and collaborative working for population health and wellbeing

Non-core (defined) areas

5. Health improvement

6. Health protection

7. Public health intelligence

8. Academic public health

9. Health and social care quality (Public Health Resource Unit and Skills for Health, 2009)

Health promotion is referred to in the framework as health improvement. The competences for senior practitioners and managers are set out in the Table 1 below.

Table 1:Extract from Health Improvement Competences: Public Health Skills and Career Framework

Level 6 **Health Improvement (= Health Promotion) – Senior Practitioner level**	**Level 7** **Health Improvement (= Health Promotion) Manager or Programme lead**
1. Involve communities and the public in assessing their health and wellbeing and needs, and identifying approaches to addressing these needs 2. Involve communities and the public in the planning, implementation and evaluation of health improvement programmes and projects 3. Plan, implement and review health improvement programmes and projects in various settings 4. Develop resources to support health improvement and the reduction of inequalities for a range of audiences 5. Support communities and the public in articulating and advocating for health and wellbeing and their health concerns.	1. Lead on the implementation and review of health improvement programmes across agencies, partnerships and communities 2. Manage health improvement programmes across agencies, partnerships and communities 3. Advocate for communities' health and wellbeing and their concerns.

Ideally competences for health promotion would be framed by a health promotion rather than a public health discourse. However there was an over-riding drive to fit in with national framework for public health. The domains of competency developed by the Galway Consensus (SOPHE, 2008)

provide an interesting comparison. The Galway Conference aimed to encourage 'global exchange and understanding concerning domains of core competency in the professional preparation and practice of health promotion and health education specialists'. The identification of core competences, standards, and quality assurance systems were seen to be essential for developing and strengthening the capacity to improve public health in the 21st century. Eight domains of core competency were identified:

- Catalyzing change
- Leadership
- Assessment
- Planning
- Implementation
- Evaluation
- Advocacy
- Partnerships

Mittelmark (2008: 3) notes that professions are characterised by 'specialised bodies of knowledge, a client base, self-regulated accountability and strict guidelines for membership'. In relation to health promotion in England, while there are a number of postgraduate health promotion courses possession of such a qualification is not a pre-requisite – although many health promotion specialists have this qualification on entry or are supported to undertake courses on a part-time basis after being appointed.

There is currently no formal regulation of health promotion – for some this is seen as a barrier to proper professionalization. Some developments are beginning to take place with regard to systems for voluntary regulation – but again within the context of public health. The voluntary nature of regulation means that it is not a legal requirement, but it is anticipated that it will increasingly be advantageous or even necessary for those seeking employment to be registered. The primary driver for the introduction of registration is to raise standards of practice and protect the public although at the same time it can raise the professional standing of practitioners (UK Public Health Register, 2008).

Since 2003 registration has been possible for those working at specialist levels in public health though The UK Voluntary Register for Public Health Specialists (UKVRPHS). There is a standard education and training route and until 2006, a retrospective route through portfolio assessment for already experienced staff based on ten key areas of practice with detailed competencies for each. Since 2006 a defined specialist arm has provided opportunity for health promotion specialists working at a senior level to register. There are, as yet, no nationally agreed training programmes for health promotion. Retrospective portfolio assessment will therefore be the main route to registration at the moment (Somervaille and McEwen, 2007). (see

<http://www.publichealthregister.org.uk/files/defined%20Assessment%20Framework%20april%202009%20appn%203.pdf> for more information). Currently the arrangements for practitioner level registration are being developed.

Additionally training for health promotion practitioners is also beginning to receive attention. It is anticipated that this will be informed by the competences defined in the Public Health Skills Framework. However some concerns have been expressed that education and training should address more than just technical competency and include consideration of the values which are integral to critical reflective practice (Naidoo and Wills, 2005).

Evidence into practice

We noted above that one of the key functions of health promotion is ensuring that programmes are evidence-based. Health promotion has challenged the dominance of traditional experimental approaches for evaluating interventions and has developed broader approaches more suited to the complex strategies and processes which typify its ways of working - in particular the need to use qualitative as well as quantitative methods to assess effectiveness. Furthermore it has emphasised the importance of evaluating process as well as outcomes if interventions are to be successfully replicated elsewhere, as well as understanding in what contexts and with which targets groups interventions are effective – or indeed ineffective (Green and South, 2006). In short, health promotion is not just concerned with whether interventions work, but how, with whom, in what contexts and under what conditions.

The evidence base is frequently equated with research and evaluation findings and systematic reviews of evaluations. However it is also recognised that professional insight and expertise should form part of the evidence-base along with reference to theory.

During the period of its existence the Health Development Agency, as a national body, produced numerous influential publications on the development of an evidence base. It has now been incorporated into the National Institute for Clinical Excellence (NICE) which publishes guidance on public health issues (see http://guidance.nice.org.uk/PHG). These are largely based on systematic reviews of the evidence and the findings are field-tested with practitioners before the final guidance is produced.

Clearly health promotion staff responsible for planning interventions are expected to draw on available evidence and assess its relevance to the context in which they are working. Evidence tends to be more available on simple interventions rather than complex initiatives. In the absence of empirical evidence practitioners will need to draw on theoretical principles.

Those working in health promotion also have a responsibility to evaluate programmes rigorously and to contribute to the evidence by disseminating findings through appropriate channels. Importantly this evidence should be relevant to others working in health promotion and grounded in its core values. The generation and use of evidence should form part of a continuous knowledge transfer cycle.

Lessons learned

Assimilation within multi-disciplinary public health created something of an identity crisis for health promotion. However, there is increasing recognition of its distinctive contribution. While it is a necessary component of modern multi-disciplinary public health, it is important to recognise health promotion as a discipline and ideology in its own right. Without this recognition we will fail to nurture – and risk losing - the specific set of skills and values which it brings to modern multidisciplinary public health. Internationally health promotion is seen as an idea whose time has come (Scriven, 2007). Responding to contemporary challenges to health requires a competent, strong and vibrant health promotion workforce, the development of proper career pathways and support for the professional development of a specialist cadre of health promotion staff – i.e. those who see their role as entirely concerned with health promotion.

Key lessons to emerge from the recent experience in England are:

- Health promotion is a discipline in its own right and an essential component of multi-disciplinary public health.
- Health promotion requires strong advocates on its behalf at national and local levels.
- The provision of health promotion services is influenced by the organisational infrastructure.
- Designated health promotion services should be provided at the local level, be adequately resourced and employ a critical mass of health promotion staff.
- Attention needs to be given to career progression and the on-going professional development of staff.
- Specification of competences is a basis for setting standards of practice and developing appropriate training programmes.
- Opportunities should be available for accreditation and registration.
- Agreed training programmes should be developed with academic institutions and be properly funded.
- Defining a competent health promotion workforce should go beyond skills to include the values and ethical principles integral to health promotion.
- Health promotion practice should be evidence based and that evidence should include professional expertise and theory as well as empirical research evidence.

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